







United States...

MEDICAL CARE FOR THE PRISON POPULATION

HEARING

BEFORE THE

SUBCOMMITTEE ON INTELLECTUAL PROPERTY
AND JUDICIAL ADMINISTRATION

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

JULY 17, 1991

Serial No. 96



Printed for the use of the Committee on the Judiciary

U.S. GOVERNMENT PRINTING OFFICE

62-519 CC

WASHINGTON : 1993

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-040673-0

COMMITTEE ON THE JUDICIARY

JACK BROOKS, *Texas, Chairman*

DON EDWARDS, *California*
JOHN CONYERS, JR., *Michigan*
ROMANO L. MAZZOLI, *Kentucky*
WILLIAM J. HUGHES, *New Jersey*
MIKE SYNAR, *Oklahoma*
PATRICIA SCHROEDER, *Colorado*
DAN GLICKMAN, *Kansas*
BARNEY FRANK, *Massachusetts*
CHARLES E. SCHUMER, *New York*
EDWARD F. FEIGHAN, *Ohio*
HOWARD L. BERMAN, *California*
RICK BOUCHER, *Virginia*
HARLEY O. STAGGERS, JR., *West Virginia*
JOHN BRYANT, *Texas*
MEL LEVINE, *California*
GEORGE E. SANGMEISTER, *Illinois*
CRAIG A. WASHINGTON, *Texas*
PETER HOAGLAND, *Nebraska*
MICHAEL J. KOPETSKI, *Oregon*
JACK REED, *Rhode Island*

HAMILTON FISH, JR., *New York*
CARLOS J. MOORHEAD, *California*
HENRY J. HYDE, *Illinois*
F. JAMES SENSENBRENNER, JR.,
Wisconsin
BILL MCCOLLUM, *Florida*
GEORGE W. GEKAS, *Pennsylvania*
HOWARD COBLE, *North Carolina*
D. FRENCH SLAUGHTER, JR., *Virginia*
LAMAR S. SMITH, *Texas*
CRAIG T. JAMES, *Florida*
TOM CAMPBELL, *California*
STEVEN SCHIFF, *New Mexico*
JIM RAMSTAD, *Minnesota*

JONATHAN R. YAROWSKY, *General Counsel*
ROBERT H. BRINK, *Deputy General Counsel*
ALAN F. COFFEY, JR., *Minority Chief Counsel*

SUBCOMMITTEE ON INTELLECTUAL PROPERTY AND JUDICIAL ADMINISTRATION

WILLIAM J. HUGHES, *New Jersey, Chairman*

JOHN CONYERS, JR., *Michigan*
MIKE SYNAR, *Oklahoma*
PATRICIA SCHROEDER, *Colorado*
DAN GLICKMAN, *Kansas*
BARNEY FRANK, *Massachusetts*
CHARLES E. SCHUMER, *New York*
RICK BOUCHER, *Virginia*
MEL LEVINE, *California*
GEORGE E. SANGMEISTER, *Illinois*

CARLOS J. MOORHEAD, *California*
HOWARD COBLE, *North Carolina*
HAMILTON FISH, JR., *New York*
F. JAMES SENSENBRENNER, JR.,
Wisconsin
CRAIG T. JAMES, *Florida*
TOM CAMPBELL, *California*

HAYDEN W. GREGORY, *Counsel*
ELIZABETH FINE, *Assistant Counsel*
LINDA C. HALL, *Editor*
PHYLLIS HENDERSON, *Staff Assistant*
VERONICA L. ELJGAN, *Staff Assistant*
THOMAS E. MOONEY, *Minority Counsel*
JOSEPH V. WOLFE, *Minority Counsel*

(II)

91-112332

KF27
.J857
1991q

CONTENTS

HEARING DATE

July 17, 1991	Page 1
---------------------	-----------

OPENING STATEMENT

Hughes, Hon. William J., a Representative in Congress from the State of New Jersey, and chairman, Subcommittee on Intellectual Property and Judicial Administration	1
---	---

WITNESSES

Alexander, Elizabeth, associate director of litigation, National Prison Project, the American Civil Liberties Union	60
Blitzstein, Herbert, prison inmate	43
Greifinger, Robert B., M.D., deputy commissioner and chief medical officer, New York State Department of Correctional Services	107
Landucci, Dante, M.D., former chief of health programs, Bureau of Prisons Metropolitan Detention Center, Los Angeles, CA, and, previously, Medical Officer, U.S. Medical Center for Federal Prisoners, Springfield, MO	115
Mayley, Sidney, prison inmate, accompanied by Mark D. Streed, attorney, Meshbasher, Singer & Spence, Ltd., Minneapolis, MN	39
Quinlan, J. Michael, Director, Federal Bureau of Prisons, accompanied by Dr. Kenneth Moritsugu, Assistant Director for Health Services	5
Reino, Rinaldo, prison inmate	45
Thorburn, Kim Marie, M.D., medical director, Hawaii Department of Public Safety	95

LETTERS, STATEMENTS, ETC., SUBMITTED FOR THE HEARING

Alexander, Elizabeth, associate director of litigation, National Prison Project, the American Civil Liberties Union: Letter from Wallace H. Cheney, Assistant Director/General Counsel, Federal Bureau of Prisons, to Elizabeth Alexander, July 16, 1991	62
Prepared statement	67
Greifinger, Robert B., M.D., deputy commissioner and chief medical officer, New York State Department of Correctional Services: Prepared statement ..	109
Landucci, Dante, M.D., former chief of health programs, Bureau of Prisons Metropolitan Detention Center, Los Angeles, CA, and, previously, Medical Officer, U.S. Medical Center for Federal Prisoners, Springfield, MO: Prepared statement	120
Quinlan, J. Michael, Director, Federal Bureau of Prisons: Prepared statement	8
Thorburn, Kim Marie, M.D., medical director, Hawaii Department of Public Safety: Prepared statement	99

APPENDIXES

Appendix 1.—Letter from Chairman William J. Hughes, to J. Michael Quinlan, Director, Bureau of Prisons, August 1, 1991	137
Appendix 2.—Letter to J. Michael Quinlan, Director, Bureau of Prisons (with attachments), to Chairman William J. Hughes, September 16, 1991	141
Appendix 3.—Letter from J. Michael Quinlan, Director, Bureau of Prisons, to Chairman William J. Hughes, October 10, 1991	159

IV

Page

Appendix 4.—Letter and magistrate's report and recommendation from Mark D. Streed, Esq., Meahbeaher & Spence, Ltd., to Elizabeth Fine, assistant counsel, Subcommittee on Intellectual Property and Judicial Administration, September 10, 1991	161
Appendix 5.—Letter from Ronald L. Kuby, Esq., law office of William M. Kunstler (transmitting statement of Dr. Alan Berkman), to Elizabeth Fine, assistant counsel, July 17, 1991	195
Appendix 6.—Letter from Rinaldo Reino, prison inmate, to Chairman William J. Hughes, August 12, 1991	222
Appendix 7.—A series of articles from the Dallas Morning News concerning medical care in Federal prisons	225

MEDICAL CARE FOR THE PRISON POPULATION

WEDNESDAY, JULY 17, 1991

**HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON INTELLECTUAL PROPERTY
AND JUDICIAL ADMINISTRATION,
COMMITTEE ON THE JUDICIARY,
Washington, DC.**

The subcommittee met, pursuant to notice, at 10:20 a.m., in room 2141, Rayburn House Office Building, Hon. William J. Hughes (chairman of the subcommittee) presiding.

Present: Representatives William J. Hughes, George E. Sangmeister, Carlos J. Moorhead, Howard Coble, Hamilton Fish, Jr., and F. James Sensenbrenner, Jr.

Also present: Hayden W. Gregory, counsel; Elizabeth Fine, assistant counsel; Veronica L. Eligan, staff assistant; and Joseph V. Wolfe, minority counsel.

OPENING STATEMENT OF CHAIRMAN HUGHES

Mr. HUGHES. The Subcommittee on Intellectual Property and Judicial Administration will come to order.

I apologize for the delay, but, unfortunately, we've been waiting for a quorum.

Good morning. The Chair has received a request to cover this hearing in whole or in part by television broadcast, radio broadcast, still photography, or by other similar methods. In accordance with committee rule 5(a), permission will be granted unless there is objection.

[No response.]

Mr. HUGHES. Hearing none, such coverage is permitted.

We are here today to address an important issue regarding our Nation's prison system: medical care for the prison population. Anticrime legislation, enacted by Congress, has brought about a marked increase in the Federal prison population. Ten years ago the population stood at 23,000; 2 years ago it was 49,000; 3 months ago it was at 61,500, and today it is over 63,000 inmates. Congress must now make certain that the Bureau of Prisons has the necessary infrastructure to keep up with the population explosion. The burgeoning population creates a multitude of challenges; among these is providing prisoners with proper health care.

The Bureau of Prisons has an ambitious expansion program in place to alleviate prison overcrowding and to make space for the growing population. I commend the Bureau of Prisons, and particularly Director Quinlan, for the vigorous efforts his agency has made to manage that growth.

However, programs and services in the prisons, including work opportunities, drug treatment, counseling, and health care, are strained by the accelerated growth. These services are essential to assure safe and humane prison conditions for inmates and staff alike.

Today this subcommittee will consider the adequacy of medical care provided in Federal prisons. Prisoners, whether in State or Federal institutions, are entitled to receive medical treatment. The Supreme Court has held that the deliberate indifference of prison officials to the medical needs of the inmate population constitutes cruel and unusual punishment in violation of the U.S. Constitution.

Prison medical care improved generally over the last decade, and I am confident that many, if not most, inmates in the Federal prisons now receive sound medical care and are healthier than they would be if they were not in prison today. However, we have recently learned of a number of troubling cases that suggest in certain areas there is still work to be done to fortify the Bureau's medical care system.

In particular, I am concerned that certain inmates have had to wait unusually long periods of time to get proper medical attention, allowing potentially treatable health problems to get out of hand. For example, one woman incarcerated at the Federal prison in Lexington, KY, recently wrote that after 2 years of medical problems and complaints, she was diagnosed as having ovarian cancer. The cancer had spread so extensively that even with regular chemotherapy treatments, she may have less than 1 year to live. While I understand that ovarian cancer can be difficult to detect, this inmate apparently did not have a routine gynecological exam during the entire 2-year period. I understand that another inmate had his leg amputated when an infection went untreated for a long period of time. Delays of this nature are not only unacceptable from a moral and constitutional standpoint, they incur far greater costs in the long run than screening and preventive care.

In addition, medical staff may not always have proper training for certain medical procedures they perform. In one recently publicized case, a Bureau of Prisons doctor performed a specialized surgical procedure on an inmate for which the doctor apparently had no appropriate training. A district court in Texas awarded the now former inmate \$400,000 in damages for negligent surgical care.

I have learned of other problems as well regarding the transportation of inmates who are sick, the widespread vacancies in health care positions, and the mismanagement of medical records. We hope that today's hearing will allow us to determine whether the cases that we have learned about to date reflect pervasive problems in the Bureau of Prisons' health care system or are instead isolated incidents.

I am certainly aware that the very best doctors and the very best hospitals cannot guarantee that every patient will recover or that medical treatment will always succeed; nor are these hospitals and their medical staffs entirely insusceptible to error. We also understand the unique problems and security concerns that the Bureau faces in providing medical care to a prison population. We do not attempt to judge the Bureau by an unrealistic standard or suggest

that it implement medical procedures that would threaten the security of staff.

We are holding today's hearing as a starting point. I plan to visit a number of Bureau of Prisons facilities, including the medical facilities in Springfield and Rochester, in order to assess conditions firsthand. Indeed, just within the past 10 days, I traveled with Director Quinlan to Marion, IL, to visit that particular facility. It's my hope to visit another facility later this week. So, I'm making an effort to take a firsthand look at the prisons.

I know my colleague from California, the ranking Republican, is interested in those visits, and my colleague from North Carolina, Mr. Coble, spent a day with me. Just 1 week ago, we visited Marion. I appreciate his traveling with me. I know he could have been back in North Carolina doing many other things, and I appreciate that.

We also hope to later explore questions regarding mental health treatment, AIDS, and women's health care. I really look forward to the testimony this morning and to working constructively with the Bureau of Prisons on this and many other issues during this and future Congresses.

The Chair recognizes the distinguished gentleman from California, Mr. Moorhead.

Mr. MOORHEAD. Well, thank you, Mr. Chairman.

Needless to say, the issue of corrections with all of its many facets is a very important part of this subcommittee's jurisdiction. In that regard, I want to commend you, Mr. Chairman, for scheduling this hearing on medical care in the Federal Bureau of Prisons as well as your announced intention to look at several other issues in the corrections field.

The challenge to provide safe, effective, and humane medical care in a prison setting is a daunting challenge. Today that challenge for the Federal Bureau of Prisons is compounded, I believe many times over, by the unprecedented growth of the Federal inmate population. Such rapid growth can't help but significantly strain all the Bureau's programs and resources, and not just those related to medical care.

Today we will hear from several distinguished witnesses as we look for constructive approaches and recommendations as to how the Federal Bureau of Prisons can best provide a system of medical care for its inmates. I've had a chance to visit Atlanta, Marion, and Marianna and other prisons across the country. In each instance we've looked at the medical care that's provided in those institutions. They have a large population, and it's very difficult to take care of every single need that the inmates may have. However, as I look at some of the more elderly of the patients and those who are chronically ill, it would seem to me that we as a society could find some better way of taking care of those that are obviously not going to be able to do any damage out in the world. Here they are dying from lack of what they need, almost constant care, in the prisons, and it's a real problem for the prison authorities as well as for the inmates and their families.

I've had constituents in similar circumstances, and I know as they get up in years they get sick and they're still in prison. It

would seem to me that we could do better than warehousing them in those later years.

I don't know what we need to do as far as medical care for the average individual that's in prison. Perhaps if there were periodic examinations, at least we would be able to see about the problems that you had with the woman who came up with ovarian cancer. Surely they should have the annual gynecological examinations that others on the outside need in order to maintain their health.

It is a problem. It's one that we need to look at and we need to find some answers to. I think that we can do that. I certainly want to join you, Mr. Chairman, in commending Mike Quinlan for the job that he is doing. Certainly he has brought modern technology to the prisons of our Nation. He should be commended for it.

Thank you, Mr. Chairman.

Mr. HUGHES. I thank the gentleman from California.

Do any other members have an opening statement? If not—

Mr. SANGMEISTER. Just a few words.

Mr. HUGHES. The gentleman from Illinois.

Mr. SANGMEISTER. I'd like to commend our chairman also for getting into this particular area. I'd expect if you'd talk to the average American out there, he could care less what the health care is in our Federal penitentiaries, but that is something that this committee cannot ignore. Mr. Chairman, you should be commended for going forward. It will be interesting to hear from witnesses we have here today.

I would have liked to have made the trip to Marion with you a week or two ago, whenever it was you went. I have been there twice before. Obviously, it's in my State. I also thank you for taking the time to go to Marion to see firsthand what's involved there. We're looking forward to the testimony of the witnesses today. Thank you.

Mr. HUGHES. I thank the gentleman.

The gentleman from North Carolina.

Mr. COBLE. Mr. Chairman, I would be remiss—if the gentleman who didn't go to Marion commended you for the trip. I think I who did accompany you should at least comment briefly. I think the trip to Marion was a very meaningful day. I think we all benefited from it. I look forward to hearing the testimony that will be presented today, even though I have another Judiciary subcommittee hearing going on now. I may have to split my time between the two. But, the trip to Marion was a good trip, and I regret that others couldn't have made the trip with us.

Thank you, Mr. Chairman.

Mr. HUGHES. I thank the gentleman.

We are now pleased to welcome Mr. J. Michael Quinlan, the Director of the Federal Bureau of Prisons, and Dr. Kenneth Moritsugu, the Assistant Director for Health Services. Mr. Quinlan has served as the Director of the Federal Bureau of Prisons since 1987 and has done an outstanding job setting high standards for government service.

Dr. Moritsugu is an Assistant Surgeon General and the Medical Director of the Federal Bureau of Prisons. He's responsible for the health care of over 63,000 Federal inmates and detainees. During his tenure, the inmate population has increased dramatically, and

the job of providing medical treatment for the prison population has become that much more challenging.

We thank you for appearing today, Mr. Director and Doctor. We have your prepared text, which is extremely comprehensive. Without objection, it will be made a part of the record in full. We hope you can summarize for us, but you made proceed as you see fit. Welcome.

STATEMENT OF J. MICHAEL QUINLAN, DIRECTOR, FEDERAL BUREAU OF PRISONS, ACCOMPANIED BY DR. KENNETH MORITSUGU, ASSISTANT DIRECTOR FOR HEALTH SERVICES

Mr. QUINLAN. I'd like to thank you and the other members of the subcommittee who have taken the time out of your very busy schedules to visit Federal institutions. That is not only important, as you point out, to learn about the concerns and issues firsthand, but it's also sends a very reassuring and positive message to the staff of the Bureau of Prisons that you care and are interested in the issues that we deal with on a daily basis.

I would like to take a few minutes to point out a couple of issues that are included in my testimony that I think are important to summarize. First of all, it is the mission of the Bureau of Prisons to provide essential medical, dental, and mental health care consistent with community standards. We should provide no less, and I agree with the comments that were made in the opening statements. We have a high obligation from which we do not shirk, and we will move ahead together to improve as situations warrant.

We believe we provide, quality care in a very cost-effective manner. We have a very professional staff who are dedicated and hard-working, and work under sometimes very trying conditions. About a quarter of our staff are Public Health Service career professionals. The balance of the staff are civil service employees. The civil service employees sometimes have a very difficult time staying with us for a career because of the disparity in pay that exists in the community health positions. It's hard to recruit and it's hard to retain people. But, it's also very difficult for us to recruit physician assistants and nurses in a nation which has shortages of those people in the noncorrectional world.

The Bureau of Prisons augments to a very large extent our own in-house medical staff with outside community consultants. There is practically no situation that is beyond just the routine type of care that we don't use, either through verbal consultation or in-person consultation, outside consultants. We will continue to work with the community in providing that kind of overall medical care.

Inmates sometimes use services based on their wants and desires, not fully understanding and being able to distinguish what is a medical need and what is merely something that they might want to have. That does tend to overutilize the medical services that we do have available.

It will probably surprise you to know that 10 percent of the 63,000 Federal prisoners use our medical services today and every day that we operate. And we operate, obviously on a 5-day-a-week basis, full medical services. So, the access of prisoners to health care is generally better than the access that free Americans have to health care in the community.

The critical point here also is that prisoners don't generally have a good history in dealing with medical problems. Many of them come from poor backgrounds where they did not have access. Many of them come from countries where there was no readily available medical care.

We calculate, based on the fact that many of our offenders have abused drugs and other substances before incarceration, that their physiological age is about 6 to 10 years older than their chronological age. That makes the need for our medical services for a prison service that has an average offender at age 37 needing more medical care than one would normally think.

Inmates have access to certain facets of our medical care virtually 24 hours a day in cases of emergency. There's daily sick call in our institutions when medications are available. All of these services are provided at no charge.

The medical staff that we employ are all licensed. There have been criticisms leveled against the Bureau of Prisons because we formerly had one physician who was unlicensed and practicing at one of our facilities. That physician is no longer providing direct patient care. The reason he worked for us unlicensed was because he was not required by the Public Health Service to have a State license. That rule has changed, and he is now in the process of obtaining a license. Every physician providing direct physician services is licensed by one or more States.

The Bureau has sustained a great deal of criticism in the media over the past few years. I think some of it may have been deserved and some of it may have been sensationalized, based on a few examples taken out of context maybe—in the large context of a prison system that is providing daily medical care to 63,000 individuals.

I do not believe that we should escape criticism for any mistakes. I believe we should be appropriately sanctioned and criticized. But, it is unfair, I believe, of the media to sometimes assume that we should be perfect. We are not perfect. We will never be perfect, although together I think we can work toward a better system than we have today.

The important thing is that we continue to recognize the importance of quality care. We have subjected ourselves to not only internal reviews, but audits by the Joint Commission on Accreditation of Health Care Organizations, as well as the American Correctional Association. We have now employed a full-time quality assurance manager who is working diligently to ensure that our programs not only provide quality care, but also that the outcomes of the work that we do are the outcomes that were desired.

We put a lot of attention on promoting good health in our institutions. We don't just look at this as a service that we are going to provide to individuals who become ill. Rather, we look at it as a long-term preventive care environment where we can promote inmate wellness, heart-healthy meals, health education, chronic care clinics, and the concept that inmates must take responsibility for their health.

There are several issues that we have experienced in the past, as you mentioned in your opening comments, about medical records and medical transportation. I assure you, and I will continue to assure you, that I will direct full attention to these problems. We are

not where we need to be. It will take continued emphasis on our part. We have the resources to do it. It's a question of making sure that we do it right.

We have a number of our offenders now who are suffering from HIV infection. This is a problem that is inherent around the Nation. I think we do as good a job as can be done to provide quality care for people who are infected with the AIDS virus. We were recognized by the President's Commission on the HIV Epidemic as being a model for prison systems in the provision of quality care for HIV-infected people.

We believe fully in the concept of educating our staff and inmates on the dangers of making improper contacts with persons where bodily fluids might be involved, and so that is our primary mode of defense against the spread of the disease within the prison. We believe that the prisoners who have AIDS in the Federal prison system are receiving the same treatment as those in the community. We have a hospice program for those who are suffering from terminal illnesses, and we have on occasion released prisoners early if their family has requested it and they have the resources to manage their cases within the community.

That's just a brief summary, Mr. Chairman, but I appreciate the opportunity. We'd like to answer any questions you might have.

Mr. HUGHES. Thank you very much, Mr. Director.

[The prepared statement of Mr. Quinlan follows:]

PREPARED STATEMENT OF J. MICHAEL QUINLAN, DIRECTOR, FEDERAL BUREAU OF PRISONS

Mr. Chairman and members of the Committee, I appreciate the opportunity to appear before you to provide an overview of medical care in the Federal Bureau of Prisons.

Overview

The health care mission of the Bureau of Prisons is to provide essential medical, dental, and mental health services to inmates by professional staff consistent with acceptable community standards, in a cost-effective manner.

Essential health care includes emergency care such as for a heart attack or appendicitis as well as care without which an inmate might experience serious deterioration of a condition, a reduced chance of recovery, or significant pain or discomfort. Unless there is a specific medical or other indication, we do not routinely provide care that may be medically acceptable but is not presently necessary, or care that is purely cosmetic in nature.

Each Bureau facility has a health care unit that provides medical care consistent with the needs of its particular inmate population, staffed by qualified Bureau health care providers. Each provider is appropriately licensed, certified, or otherwise credentialed, consistent with applicable regulatory requirements. The Bureau complements and augments its internal facility and professional assets with locally available resources, consistent with community standards, utilizing external consultants as well as hospital and other diagnostic and therapeutic resources as appropriate.

We acknowledge that medicine is not an exact science, in the community at large, as well as within the Federal Bureau of Prisons. As with any large health care system, the Bureau's system has elements that are outstanding and others that could be improved. We do not purport to be perfect, but we continue to strive for excellence in our services. We continuously evaluate our system, to identify strengths as well as weaknesses, and to develop actions for improvement when we identify problems.

Access and Range of Services

Because of constitutional and other legal considerations, inmates may have access to health care not regularly available to the average tax-paying, law abiding citizen. Our institutions hold regular sick call five times a week, and emergency care is available around the clock. Our system provides the full spectrum of services to assure appropriate treatment, from primary care ambulatory services, to specialty consultations, to hospitalization and even hospice care where necessary and appropriate. This includes medical, dental, as well as mental health services.

Wellness, Health Promotion, and Disease Prevention

Moreover, as part of the Bureau's commitment to wellness, and consistent with educating inmates to take an increasing responsibility for a healthy lifestyle, both while incarcerated, as well as after their release, we endorse and actively promote the concepts of health promotion and disease prevention. To this end, we offer programs in preventive care, such as chronic care clinics providing continuity of care as well as health education to inmates with particular medical needs.

000001

Our food service program emphasizes heart healthy diets and nutrition education. We prepare food using little fat and salt, and offer alternatives to fried foods. We encourage inmates to make wise dietary choices by offering such items as fresh fruit and salad bars.

Utilization of Services

A major difficulty we face is the tremendous level of utilization of services by inmates. Inmates, in general, have not had access to good medical services prior to incarceration, or have not taken good care of their health. We also have a large number of individuals from countries with substandard health care practices. Many Federal inmates have histories of drug or alcohol abuse which places additional stress on our health care system. With this in mind, our physicians feel that conceptually the physiological age of many of our inmates is 6 to 10 years greater than their chronological age, and they often experience the health care problems of individuals much older than their stated age.

There are few costs or disincentives for inmates, who may often overutilize health care services by attending to their individual wants, rather than true health care needs. In addition to bona-fide medical needs, some may use a visit to the health service unit as a work diversion, a social event, or an opportunity to break the boredom of institutional living. Upwards of ten per cent of an institution's population may demand health care attention on a given day. This utilization creates tremendous pressure on a system which is responsible for the care as well as the custody of these individuals.

Human Resources

Perhaps the most critical issue is human resources. With our rapid expansion from approximately 48,000 inmates 5 years ago, to over 62,000 inmates today, to a projected 98,800 inmates by 1995, we will continue to experience tremendous pressures in recruitment and retention of health care professionals, to meet the health care needs of this group.

Part of the concern about medical care in the Bureau centers around misperceptions of our medical personnel's qualifications and abilities. On March 17, the CBS 60 Minutes program broadcast a segment titled "It's the Law," which grossly misrepresented our agency and was unfairly critical of the quality of care available to Federal inmates. We furnished the producers with medical statistics and records, facilitated their visits to institutions, and coordinated their requests to interview staff and inmates. Despite our cooperation, CBS selectively edited the segment to present an unbalanced view of inmate health care delivery in the Bureau. 60 Minutes led viewers to make conclusions based on a limited review of only three cases with untoward outcomes. Our medical staff were portrayed as calloused and uncaring, to which I personally take very strong exception. I am proud of the Bureau's medical professionals, administrators, and support staff and, with them, feel affronted by the 60 Minutes segment.

Despite difficulties in recruitment and retention, the Bureau of Prisons is fortunate to have dedicated, talented, conscientious, and well-trained health care professionals to staff its health care program. The system is based on physician assistants as the first line of health care response, a profession which is specifically trained to function as primary assistants to the physician, to provide a high level of care to our inmates under the direct supervision of a physician. A significant number of our physicians have completed specialty residencies, and are board eligible or board certified.

To complement Bureau of Prisons medical staff, the U.S. Public Health Service (PHS) provides the Bureau with physicians, dentists, psychiatrists, nurses, psychologists, hospital administrators, and pharmacists. We have approximately 350 PHS officers assigned to the Bureau -- 22 percent of our health care employees. However, even the PHS is limited in its ability to meet all our requests for care providers.

One recruitment source for a number of years has been the Public Health Service's National Health Service Corps, which provides obligated scholars for service in underserved areas, including Bureau institutions. However, with reductions in the program, this source of medical staff is drying up. Based on our growth, we continue to pursue recruitment strategies aggressively.

Three years ago, our staffing complement in health services had deteriorated to a 26 percent vacancy rate in the aggregate. As a result of an all-out initiative to address this critical need, we were successful in reducing that vacancy rate in health care personnel to 10 percent by 1991. Still, our inability to fully staff facilities has led to some recent public image problems, although for the most part we have been able to complement our staffing shortfalls with local community resources. Additionally, with the continuing rapid growth of the inmate population, our health provider needs will concomitantly increase, and we will have to maintain our focused efforts to recruit and retain increasing numbers of health professionals.

Inability to effectively compete with private sector health care systems and other attractions of private practice is a major problem in the recruitment and retention of these necessary human resources. Despite our efforts to communicate the attractions and satisfactions of practicing correctional health care, we cannot adequately respond to private sector salary scales two or even three times the maximum we can offer.

The American Academy of Physician Assistants reports that six job offers exist for every newly graduating physician assistant; that in certain metropolitan areas, physician assistants can earn in excess of \$50,000 annually; and that the output of Physician Assistant Training Programs cannot keep up with the demand for their graduates.

The nursing shortage is acute across the nation; and in cities in which the Bureau's major medical centers are located, a bidding war has erupted to attract nurses from one private hospital to another. Nurses are receiving cash bonuses from one private hospital just for showing up to work, and in other cases, are receiving full weekly salaries for compressed work weeks.

It is difficult to attract physicians from private practices where they may be making over \$250,000 annually, to a maximum government salary of under \$110,000, including the special physicians comparability pay.

Among our strategies, we now waive maximum age restrictions for physicians and physician assistants, raise age limits and exercise maximum flexibility in work schedules for nurses, provide a generous continuing professional education program, and publicize that Federal physicians do not need to pay staggering malpractice premiums. Nevertheless, the inability to offer competitive salaries has severely hampered our ability to recruit and retain the numbers of quality health care providers we would like to have in our system.

Our recruitment would be significantly enhanced if we had the ability to offer competitive salaries. In view of the continuing competition in the non-Federal sector, health professional pay scales indexed to community levels, would be preferable to simply raising salaries within a mandatory, nation-wide cap, which would quickly be matched and exceeded by private systems.

Description of the System

The care we provide at any facility is based on the size and characteristics of the inmate population. Each Bureau facility operates, at a minimum, a primary care, ambulatory clinic staffed by licensed physicians, dentists, nurses, physician assistants, and other providers. To the extent necessary, we augment our internal services with community consultants, to provide care consistent with community standards.

Where indicated, we transfer inmates requiring more extensive or extended hospitalization or specialty care to one of our seven specialized medical centers, which use both in-house staff and community medical resources to provide such services. The Federal Correctional Institution in Butner, North Carolina, has a mental health care facility for 138 male inmate-patients. The Federal Medical Center in Carville, Louisiana, is a chronic care unit which will house approximately 200 male inmates. The Federal Correctional Institution in Fort Worth, Texas, has a chronic care and skilled nursing facility for 225 male inmates. The Federal Correctional Institution in Lexington, Kentucky, is our major medical and psychiatric center for female inmates, with a capacity for 199 female inmate-patients. The Federal Medical Center in Rochester, Minnesota, is primarily a medical and psychiatric treatment center with a capacity of 371 beds, mainly for male inmates. The Medical Center for Federal Prisoners in Springfield, Missouri, is primarily a medical and psychiatric treatment center with capacity for 730 male inmate-patients. The Federal Correctional Institution in Terminal Island, California, has a 13-bed infirmary for male inmates on the West Coast.

In view of our immediate as well as projected needs stemming from the rapid growth of the inmate population, as well as our projected needs for long-term hospital beds as we project a gradually "greying" population, we have embarked on an ambitious expansion program for increasing our hospital bed capacity throughout the system. We have entered into a tenant agreement with the U.S. Public Health Service for utilization of a portion of the Gillis W. Long Center in Carville, Louisiana, as a long-term care facility, with the intent of gradually increasing our presence and the number of hospital beds at that site. Further, we have developed a plan for the construction of approximately 2500 new hospital beds over the next decade, located principally as part of our future correctional complexes, to accommodate projected needs. The first of these, the Federal Medical Center at Butner, North Carolina, will be constructed as part of the Federal Correctional Complex, and should be on line in 1995. Additional Federal Medical Centers will be programmed into future budget requests beginning in FY 1993.

As part of our ongoing facility maintenance program, we are carefully assessing our existing special medical facilities to determine their period of useful life, and the amount of maintenance each will require as their missions evolve according to system needs.

Inmate Transportation

Coordinating inmate transportation to and from medical centers is a complicated task, given the geographic spread of institutions and the extensive network of U.S. Marshals Service airplanes and Bureau of Prisons buses traveling across the country. This network allows for the systematic transfer of about 35,000 Federal inmates and detainees each year. In 1990, we had 5,117 medical transfers. Of these, 3,103 were to a medical referral center -- some using the inmate transportation system and some on special air charter flights. In other cases, we transferred inmates to another facility that is not a specialized medical center, but which has the in-house capability or specialized community assets necessary for particular procedures.

Inmates who require emergency care are usually taken to a hospital near their institution. Those who can be transported greater distances for emergency care are flown by air charters to a Bureau medical facility. Individuals whose medical conditions do not require emergent local care or immediate air transportation, routinely travel by surface vehicles to a Bureau medical facility. While such travel might mean extended bus rides or intermittent stops in holdover facilities as we attempt to move inmates efficiently throughout our nationwide system, we do so only within the dictates of sound medical judgment, and do not utilize this mode of transportation to move an inmate who is not medically stable, or whose medical condition would be a contraindication.

Managed Care

Our goal is to provide quality patient care that is consistent with community standards, and to manage our system using proven administration principles. Our emphasis on managed care stresses continuing quality improvement coupled with aggressive cost containment.

As in society in general, the Bureau has seen a dramatic increase in medical costs. Total costs for 1990 were \$140 million, approximately \$2,500 per inmate. In addition to an increase in medical care costs within Bureau facilities, the Bureau has incurred even greater increases when inmates require community hospitalization or consultant services provided by outside specialists.

Between 1980 and 1990, the Bureau's costs associated with outside medical care for Federal prisoners rose from \$4.1 million to \$41 million. Because of the growing number of inmates and the complexity of their medical problems, such as AIDS, the Bureau has had to seek more assistance from outside medical resources.

Quality Management

One of the hallmarks of the Bureau is its ability to address the concerns of inmates. Wardens and other institutional staff make themselves personally available to inmates during daily walks through the institution. During that time, as well as on other occasions, inmates may express their concerns about any issue regarding their care or custody. In the event these informal contacts do not resolve a problem, a formal administrative remedy process is available, through which an inmate may seek increasing levels of relief through defined appeals processes.

The Bureau is committed to validation of its operations, through the use of recognized, formal organizations whose specific mission is to review institutional policies and practices. To that end, in addition to formal internal program reviews conducted by staff of the Bureau's Program Review Division, the Bureau actively participates in the accreditation programs of the American Correctional Association, and of the Joint Commission for the Accreditation of Health Care Organizations (JCAHO). Five of our seven specialized medical institutions are fully accredited by the JCAHO. We plan to seek accreditation for our hospital operation at the Federal Medical Center in Rochester, Minnesota by the end of this calendar year, and for our long-term care facility at the Federal Correctional Institution at Fort Worth, Texas, upon completion of an 85 bed hospital at that location.

To further advance quality assurance in our health care operations, we have established an Office of Quality Management, and have hired a full-time physician, board-certified in quality assurance, to manage the program. This program has implemented health care review processes similar to those widely used in the community. While each institution has some form of internal quality assurance program designed to objectively monitor and evaluate the medical care it provides, we need to continue to increase, refine, and systematize these activities. When questionable outcomes occur, the Bureau uses outside experts or internal review teams to conduct independent reviews. The Office of Quality Management is responsible for carrying out this aspect of our health care mission.

Our internal process uses teams consisting of physicians, senior health systems administrators, and senior correctional services administrators for reviews of either specific cases or the general delivery of care. We have established a Quality Management Advisory Group to assist in the development of programs that mirror standard community practices.

Complaints, Claims, Settlements, and Judgments

One indicator of the quality of care we provide is complaints from inmates, through our internal administrative remedy process, or through the courts under habeas corpus requests or actions under the Federal Tort Claims Act.

At our Medical Center for Federal Prisoners in Springfield, Missouri, the number of medical administrative remedy requests filed is generally dropping over the past several years, from 31 in 1987, to 28 in 1988, 19 in 1989, and 24 in 1990. In the first three quarters of 1991, inmates filed a total of 9 requests; annualizing results at 12 anticipated requests. Of those filed, only 22 have been granted over the past 3 years, and none in 1991. Cases filed in medical habeas corpus actions have similarly dropped, from 79 in 1987, to 33 in 1988, 35 in 1989 and 51 in 1990. Of these nearly 190 cases filed, only 18 have been granted. In the first three quarters of 1991, of the only 7 habeas actions filed, none have been granted to date. The number of medical litigation cases (tort or Bivens) filed has also dropped, from 17 in 1987, 10 in 1988, 9 in 1989, 11 in 1990, and 4 to date in 1991. Of the 51 cases filed, 33 have been dismissed to date, with 18 remaining to be resolved.

The institution at Springfield has provided care for about 10,000 inmate-patients in the past five years. During that time, there has been only one adverse monetary judgment against the government, for \$91,000. While a second adverse medical judgement involving care at Springfield resulted in an award of \$400,000, that decision is currently under consideration

for appeal.

Further, over the past three years, systemwide the Bureau has had 22 settlements or adverse judgments in medical cases, totalling \$3.6 million dollars, an average award of \$165,000.

For any institution such as Springfield, or for any system such as the Federal Bureau of Prisons, to be able to present such a minimal record of complaints, settlements, or judgements, is noteworthy, particularly when the average jury verdict in medical malpractice cases in the community is \$1,109,660 (the average jury verdict amount for the Bureau over the last 3 years has been \$178,677). There are few hospitals or health care delivery systems in the private sector which can present such a record. With an estimate of well over 1 million patient contacts a year in our system, we believe we are continuing to provide high quality health care, at least as good as that found in the community at large.

Mental Health Programs

In the Bureau, we believe in the inherent dignity of all human beings and their potential for improvement. A key dimension of this commitment is the development of programs to identify, diagnose, treat, and rehabilitate inmates who suffer from mental illness. These programs are designed around standards promulgated by the American Psychiatric Association and the Joint Commission on Accreditation of Health Care Organizations. Our mental health care systems are designed to provide appropriate services to those in need.

Our major mental health programs and resources are concentrated at the four inpatient psychiatric referral centers in Butner, North Carolina; Lexington, Kentucky; Rochester, Minnesota; and Springfield, Missouri. In addition, we offer mental health diagnostic, evaluative, and treatment services by psychiatrists, psychologists, and other mental health professionals at other facilities.

We have created an interdisciplinary Mental Health Advisory Group to meet the challenges of an expanding population and the development of facilities for their custody and humane care. The Advisory Group has developed the model for a multilevel, stratified mental health system. As proposed, this system will build upon our existing network to form a comprehensive and integrated system with preventive, intermediate, chronic, and acute services. It will be sensitive to subpopulations whose special needs render them particularly vulnerable to mental illness or who require other special attention: foreign-born offenders, the mentally retarded, substance abusers, and the elderly. Further, it will utilize greater mobility of inmates among facilities appropriate for their conditions, to assure that each will receive the right level of mental health care, without unnecessary duplication of services at multiple sites. While fully implementing this system over the next several years will require modification of missions at certain institutions, some physical plant renovation to accommodate mental health living and treatment units, and additional mental health staff, it will be considerably less than the creation de novo of several multilevel mental health institutions. As we further define these resource requirements, we will bring our requests to the Congress.

HIV and AIDS

The Bureau understands the medical, legal, and ethical concerns revolving around the rights of HIV-infected inmates, AIDS patients, and uninfected individuals. Our approach favors the provision of the least restrictive measures consistent with the orderly management of our institutions. We place a great deal of emphasis on prevention, as exemplified in our initiatives in HIV education and counseling. Our overall program is fully consistent with the recommendations of the Centers for Disease Control.

Our education program is directed toward both staff and inmates, to ensure more responsible behavior and a continued low viral transmission rate. Within the context of universal precautions, the underlying presumption in all policy and training is that blood, semen, vaginal fluids, or any body fluids containing visible blood should be considered contaminated. Inmates receive education upon first arriving at our institutions during admission and orientation. Employees receive education regarding HIV transmission upon initial employment and annually during refresher training. Both groups receive both written and videotaped educational material on an ongoing basis.

The Bureau tests the following categories of inmates for the presence of HIV antibodies: (1) A sample of newly committed inmates who receive additional tests at regular intervals to monitor the rate of viral transmission; (2) All inmates prior to release; (3) All inmates who volunteer to be tested; and (4) All inmates displaying clinical signs of HIV infection. In the interest of confidentiality, only those staff who have a need to know are informed that an inmate is HIV-positive.

Inmates who test positive for the presence of HIV antibodies receive state-of-the-art care consistent with community standards. Clinical staff dispense AZT and pentamidine to appropriate inmates. HIV-positive inmates remain in the general population as long as they do not require acute care. Our emphasis on education, universal precautions, and professional management of HIV-positive inmates has rendered isolation unnecessary. All institutions provide nonacute care through in-house resources or contract services. We hospitalize those requiring inpatient care at our medical referral centers in Springfield, Missouri; Rochester, Minnesota; and Lexington, Kentucky. In these settings, inmates have access to numerous medical specialties, either at the institution or through visits to community-based facilities.

We believe that we have a program far ahead of other correctional systems, a program that has been specifically cited by the President's Commission on the HIV Epidemic in 1988 as a model for other systems. With one exception, our program is also fully consistent with recommendations of the National Commission on AIDS, as noted in its recent report published in 1991. Because of our dual responsibilities of care and custody, we do not feel that issuance of condoms to inmates is appropriate in our system, and do not agree with that recommendation of the Commission for the Federal Bureau of Prisons.

Humane and Sensitive Care

Our hospice programs recognize and affirm the human dignity of terminally ill inmates. We designed the program to help dying inmates work through the grieving process, build stronger relationships with their families, address personal issues before death, and accept death with peace and dignity.

As is evident, the unique setting of a correctional institution certainly presents nuances in the provision of medical care. Inmate accountability does not allow for "walk-in" access to the health care unit at all times. Sick call assessments and pill lines for the distribution of medication are scheduled to meet the population's needs, within the parameters of security. Our hospice program is a tangible example of our commitment to humane treatment, a commitment that transcends the Bureau. We continually address the issue of sensitivity toward inmate health concerns by all employees, not just health care providers.

Summary

In closing, the Bureau is committed to providing quality health care to its inmate population. Our health care system is dominated by physician-directed and physician assistant-implemented care and offers inmates an unusually high degree of access. Despite a demand-driven system, unconstrained by "marketplace" limits, health care needs are met or exceeded. We have an evolving program review process to address the rare questionable clinical outcomes. We implement corrective actions as necessary to maintain our high standards. External expert reviews show that we are providing a level and quality of care for inmates that is comparable to that available to the average law-abiding, tax-paying citizen. Further, administrative remedy requests and tort claims data fail to support the contention that we are providing poor or inadequate care as a total system. Nonetheless, we are constantly refining and expanding our clinical care provision and our health care review mechanisms to take advantage of opportunities for improvement.

This concludes my prepared statement, Mr. Chairman. I would be pleased to answer any questions that you or the other members of the committee may have concerning this important area.

Mr. HUGHES. What are the most prevalent health problems among inmates?

Mr. QUINLAN. I'm going to turn that over to Dr. Moritsugu.

Dr. MORITSUGU. The most prevalent health care problems, Mr. Chairman, relate to inmate's past behavior, an environment that may not have been the same that you and I may have had, and as we have been fortunate not to have had. Individuals come to us oftentimes without prior evaluation in the private sector. So, we find that we are picking up disease processes that otherwise would have been picked up years before in a normal setting.

Some of the conditions that we are finding are very similar to what you would see in the private sector, such as cardiovascular disease, as well as chronic lung disease. We see the full spectrum of diseases, as you would imagine, in any other large population.

Mr. HUGHES. Mr. Director or Doctor, what problems do you foresee in meeting the medical needs of special population groups in the Bureau of Prisons, including the elderly, inmates infected with AIDS or the HIV virus, and women in particular?

Mr. QUINLAN. I think the special populations do offer new challenges to the Bureau of Prison in providing quality care across the gambit of the type of offenders we receive. The Bureau has put a lot of emphasis on chronic care cases because we have been getting more and more individuals who are elderly and are physiologically elderly, more so than their years would indicate. We've just acquired access to a new facility from the Public Health Service in Carville, LA, which we will be dedicating shortly to help us cope with the problem of managing chronic care cases.

We also have implemented from the HIV standpoint, a quality program, I think, that affords throughout our system, not in just certain institutions but throughout our system, the opportunity to mainstream offenders who are infected, so that they can get the medical attention they need and yet not segregate them into locations where they're just among other prisoners who are infected with the virus. We feel that our approach is the best one.

In terms of female offenders, I must be quite candid with you. I think the Bureau of Prisons was under the mistaken notion that female offenders needed about the same medical care as male offenders at similar points in their life. Quite honestly, through some recent interactions that I've had with a number of outside experts on the subject of medical care and other issues relating to females, I have learned that females in their midthirties have many more medical concerns than a typical male offender would have in his thirties. For that reason, we are reprogramming our medical and other programmatic resources to be more focused in dealing with those types of issues for female offenders.

Mr. HUGHES. Does that include gynecological exams, for instance?

Mr. QUINLAN. I believe I'd let Dr. Moritsugu respond to that.

Dr. MORITSUGU. Yes, it certainly does, Mr. Chairman. We are not familiar with the case that you have raised. We certainly will be looking into it immediately after this hearing to find out exactly the details. Frankly, I am very concerned, as you are, as you have raised it.

We are very much committed to providing the full range of health care both to males as well as females, and to that end, are designing a systemwide female health care program centered at Lexington, KY, and have been aggressively hiring additional gynecologists to assist us in the design and the implementation of this program.

If I might add to what the Director has said in terms of special program needs of the elderly and the geriatric population: As the general population grows older, so will the population within the Federal Bureau of Prisons. To that end, we have established two specialized medical centers, one in Ft. Worth, TX, and the other in Carville, LA, to specifically address the needs of the elderly and the chronically ill.

Another program and special need that I'm sure you are familiar with is that of the drug offender, and the Director and the Bureau have made a specific and special commitment to addressing the special needs of this population.

Mr. QUINLAN. I would like to add to the response, Mr. Chairman, to your question as to what are some of the problems of the prison health care system. I think there are two other problems which deserve mention. One is, as I mentioned in my opening comments, the recruitment problem. We have a difficult time recruiting health professionals in the prison service. One reason is the pay. I think in some communities it's just totally disparate. Our pay may only be 25 or 35 percent of what a physician or health care provider can receive in the community. So, that makes it very, very difficult to retain and recruit quality personnel.

One of the other problems, though, that we're really wrestling with, and will continue to work with the committee to try to resolve, is the issue that I mentioned in my opening comments. That is the fact that 10 percent of our population will go to our clinics and our hospital facilities today. If we took that same percent of American people, we'd have 25 million people today going to the doctor, and we know that there is no way that the physicians and the medical providers in this country could ever handle 25 million people in 1 day.

We have an overutilization of our services because partially, I suppose, it's a case of a diversion from maybe a boring environment for people who are serving long sentences and they want to go up and see a health care provider; or they don't know any better how to deal with a headache or a sore throat that you and I might just say, well, I'll take a couple of aspirin and I'll just see if I can tough it out a little bit.

We have to find a way, I think, Mr. Chairman, to make our services a little less available, maybe devise some sort of a disincentive for inmates who use—I would say maybe overuse—our services. What happens as a result of this heavy use is sometimes staff gets worn down quicker than they should on particular inmate problems. We do have a number of inmates, unfortunately, who think they can manipulate us to an extent. That causes us to maybe turn away when we shouldn't turn away from a real problem.

This is an occupational hazard in working in prisons. I'm not shirking our responsibilities to deal with it. I would take the oppor-

tunity, though, to answer your question, I think very candidly, and tell you some of the issues we have to contend with.

Mr. HUGHES. Mr. Director, the 10-percent number, is that an actual count from the various facilities around the country?

Dr. MORITSUGU. Approximately 3 months ago, Mr. Chairman, we were very concerned about what we perceived to be a high utilization rate. This is also something that was brought to our attention a couple of years ago by Dr. Richard Wilbur who had done a survey of health care within the Federal Bureau of Prisons at our request. So, we did a random sample of our institutions across the country, and the numbers actually ranged between 10 percent and 15 percent of our population utilizing health care services on any specific day. So, it is a direct count; it is not merely an estimation.

Mr. HUGHES. Well, I can understand. Just with anecdotal experiences that I have had talking with inmates, some of the mail we receive, and talking with others who are familiar with medical care in the prison system, I do get the impression that it's very difficult to identify the malingerers. There's a tendency, unfortunately, when the system is overtaxed to assume that somebody who frequently seeks medical attention continues to do so for a variety of nonmedical reasons: It's somebody to talk to; it's a warm body; it gets them out of a work detail, and a whole host of other reasons.

But, how do you deal with a situation where the health professional perhaps becomes somewhat calloused by such a pattern?

Mr. QUINLAN. I would like to respond to that, Mr. Chairman, because it is something that we have been focusing on very, very heavily within the Bureau of Prisons in the past year or so. The way that we try to deal with it is primarily through focus and attention and training. Every time that we have an opportunity to speak to physicians and health providers, both Dr. Moritsugu and I speak about this problem. If people understand, I think, that it's likely to occur, they will be better able to see those situations developing and hopefully deal around them and not let them interfere with good quality medical care.

I mention this problem only as a situation that we have to contend with. It is not an excuse, Mr. Chairman, for not providing quality care. I would hope you would never let us off that easy. It is our responsibility to deal with it and to make staff aware of it.

Ken, probably you can provide more specifics.

Dr. MORITSUGU. If I might, Mr. Chairman, add to the Director's comments, that we certainly are very concerned about it, as you are concerned. It has to do with an issue of continuing sensitivity in a very, very difficult environment, particularly when you are not exactly certain whether or not a patient's complaints are real or perhaps are not quite as severe as maybe originally articulated.

To that end, I think we have taken several very, very aggressive steps. The Director, in a communication that he sends out to all chief executive officers throughout the system, has articulated this. In videotapes that we have sent around to all staff, the Director and I have both addressed this issue of maintaining a high level of sensitivity, a high level of index of suspicion because, while there may be a certain number of less than absolutely necessary requests for health care, within that group there may very well be a very valid complaint. The challenge to the health care provider is to re-

main constantly aware and alert, to watch out for those individuals who really have that need and not overlook those individuals.

As the Director also mentioned, whenever there are meetings not only of health care providers, but also of other correctional professionals within the Federal Bureau of Prisons, we take the opportunity to address this issue of sensitivity. It will be a continuing high priority area for the foreseeable future. I do not see this as an issue that can be addressed and that will go away just by mentioning it once or twice. I see this as a continuing challenge for all of us.

Mr. HUGHES. Oh, I think it's an institutional problem. I think there is no way to eliminate those periodic visits. Many of the anecdotal cases we've seen perhaps could have been prevented if, in fact, the condition had been detected earlier. I suspect that in some of these instances it's not hard for the professional, as I indicated, to become calloused and to believe that, in fact, it's just another example of faking a condition. But, that's difficult to conclude unless you make an effort to listen to them and to be a little more objective perhaps than you're inclined to be.

I see the same thing in casework in my own offices. Caseworkers get burned out. I suspect my colleagues experience the same thing because we see the same people time and again with a myriad of complaints, and it's easy to conclude that they're just complaining again. Periodically, I review with staff procedures and policies to reinforce the importance of listening to constituents because in many instances they do have legitimate complaints, although you get the ones that continually complain.

There's no easy answer to that, but it seems to me you have to continue with your training programs, your educational programs, to reinforce the need to listen to complaints, and recommit one's self to objectivity. I know that's difficult. I'm not so sure how else you can deal with it.

Dr. MORITSUGU. I appreciate your comments Mr. Chairman. There are very many similarities between practicing medicine in the private sector and practicing medicine in the correctional setting, but there are also major differences, as I'm sure you are aware. Correctional health care can be very significantly different in the practice mode. To that end, we look to see what we may have done incorrectly, and we continue to design additional training programs to assure that our health care providers will be adequately prepared to understand the challenges and the nuances of correctional health care within an institution.

Mr. HUGHES. I have a number of other questions, but we'll go to some other rounds. I'm going to recognize the gentleman from New York, the ranking Republican on the full committee, Mr. Fish.

Mr. FISH. Thank you, Mr. Chairman. I appreciate your courtesy.

As I listened to the last few minutes here, I was reminded of my days in the service many, many years ago when the military amounted to several million and sick call was a common phenomenon. I think it probably presented the same problems to the military doctors as it does to the prison physicians. We might want to talk to some of those doctors to see how they handle it.

But, Dr. Moritsugu—am I pronouncing it right?

Dr. MORITSUGU. Yes.

Mr. FISH. I was interested the other day in hearing about a medical survey that found a tremendously high incidence of glaucoma among minorities, to the point they concluded that it was genetic. Second, in the course of the survey, 50 percent of those that were discovered with glaucoma didn't know it until they were part of this survey. I should think that would be a problem for you and the inmate population that you have, considering the remarks you made at the beginning of this hearing with respect to the background and culture and whatnot.

So, could I ask you: When an inmate is incarcerated, do you start off with a thorough, long physical examination of that individual?

Dr. MORITSUGU. Yes, sir. According to our procedures, an individual initially receives a brief screening to assure that the individual does not have any major health care problems that would become critical in the short time between his or her initial admission into our system and the time at which that individual would receive a complete physical examination. That normally occurs within the first 7 to 30 days of the individual's incarceration.

Mr. FISH. The screening or the physical?

Dr. MORITSUGU. I'm talking about the full examination.

Mr. FISH. Which?

Dr. MORITSUGU. I'm sorry?

Mr. FISH. Which occurs in the first—

Dr. MORITSUGU. The screening occurs immediately. As the individual enters the institution, in what we call our admissions area there is an immediate brief screen. It is superficial, to say the least, but is designed to pick up any major problems that could occur.

Then within the first 30 days, and oftentimes much sooner than that, the individual receives a complete physical examination.

Mr. FISH. And, at that time you would hope to have a medical record or history of this individual that would alert the medical personnel at the institution about this person's condition for the time that they're incarcerated?

Dr. MORITSUGU. The physical examination does include a complete history as well, yes, sir.

Mr. FISH. Mr. Quinlan, you said something about the pay that you could afford to give the doctors being 25 to 30 percent. Twenty-five to 30 percent of what?

Mr. QUINLAN. Congressman Fish, I was referring specifically with that comment to our ability to recruit psychiatrists in urban areas where the pay approaches a quarter of a million dollars a year in the outside community and where we only are able to pay in the \$80,000 to \$90,000 range.

Mr. FISH. Oh, I see. So, your pay for doctors is comparable to the Veterans' Administration?

Mr. QUINLAN. No, I don't believe it is, Mr. Fish. The Veterans' Administration has some special legislation and some special pay provisions that do not apply to other government physicians.

Mr. FISH. Would this psychiatrist you're referring to be part-time?

Mr. QUINLAN. No, it would be a full-time psychiatrist.

Mr. FISH. It would be full-time?

Mr. QUINLAN. Yes, sir.

Mr. FISH. Well, that's interesting that the VA would be treated differently. How about the military services? How do you compare with—

Mr. QUINLAN. I'd like maybe Dr. Moritsugu to—

Mr. FISH [continuing]. The doctors in the Navy?

Dr. MORITSUGU. I'm in the U.S. Public Health Service, sir, but the pay scales are exactly the same in all seven uniformed services. The salary scales between the military services as well as within the civil service under title V are very similar when you talk in terms of actual compensation. They approach each other, although they are not exactly equivalent.

Under title 38 of the Veterans' Administration authority, there is recent legislation that provides for additional bonuses that may very well be indexed to community pay scales, and there is apparently a provision that may allow us to access certain portions of title 38. We are currently examining that, but, again, there is still a significant disparity between what we have under title V or under the military and the VA, and, more importantly, between what we in the Government service may offer a potential employee and what the private sector may very well offer.

To give you an example, among physician assistants, in talking with the American Academy of Physician Assistants, for every graduate of a PA program, there are six vacancies available to that individual. Furthermore, in certain metropolitan areas in certain specialties, physician assistants might begin at as much as \$60,000 per year, which is almost 100 percent greater than what we are able to offer within the Government.

Mr. FISH. Thank you. Mr. Quinlan, as you probably know, one of the big topics facing this Congress concerns access to medical care and affordability of medical care. These are two problems which you don't have because your population has the access and is not going to go elsewhere for it, and it's free. But, you did say that you thought that the quality of care in the prison system was equal to that of the standards in the community generally. Now I wonder if you would elaborate on that, because I would imagine that standards of care would vary in different parts of the country. I don't know if you meant that you have a single standard that is based on one geographic area or that your prisons situated around the country would have different standards of care that reflect the local community.

Mr. QUINLAN. No. The standard of care, Congressman Fish, that we apply is an unspecified national standard of care. If the prevalence in the East is that a certain medical procedure is expected under the circumstances, and it maybe hasn't reached the other part of the country, I think we would hold ourselves to the higher standard, the national standard.

Now, of course, we're going to obviously be limited in that respect because we're going to rely heavily on community support, community consultants, in all of our institutions. All of our 67 current prison locations are going to rely on local community support. Obviously, if something is not available in the local area, it makes it more difficult for us, but we do apply, I think, a high standard.

Now one of the interesting sidelights to that comment that you indicated, that the prison health care is comparable to community

health standards, is that we actually believe that we provide better care than that which is available to the 37 million Americans who have no health insurance.

Mr. FISH. Exactly. That's why I zeroed in on the words "quality," "access," and "affordability."

One final question, Mr. Quinlan, and that has to do with the care afforded to pregnant women who are found guilty and incarcerated and then while incarcerated, they have a child. What happens to them then? What happens to the mother? What happens to the child?

Mr. QUINLAN. Well, that generally will be handled at our facility for Federal female prisoners in Lexington, KY, where we have a medical center as well as a large female institution. The women will be given regular obstetrical care, and then when it's about time for the child to be born, the woman will be generally taken, in most cases, to a local community hospital for delivery. If the woman's security level would allow it, she will actually be placed in a local community home for a period of time before the delivery and for a short time after delivery.

Mr. FISH. Well, what is the policy with respect to a woman who has given birth, and yet has a year or two to run on her sentence? What accommodations are made for the mother and the baby?

Mr. QUINLAN. There are generally very few accommodations made for the mother to keep the baby, because obviously we have no statutory authority to be responsible for the baby, Congressman Fish. During the time prior to delivery, we do encourage the prospective mother to make arrangements with a family member or with an outside agency to care for the baby during the time that the mother would be incarcerated. We do not have a way to deal with the mother and the baby together, other than for a very short period of time after birth.

Mr. FISH. Well, can I recommend, finally, to you and the chairman both, the experience of the Bedford Correctional Facility for Women in Westchester County, NY, in which they have a ward—

Mr. QUINLAN. Yes.

Mr. FISH [continuing]. Where the mother and the baby live for a period of 1 year after birth. So, you have the—

Mr. QUINLAN. Yes, thank you.

Mr. FISH. I guess I've gotten to the end of my knowledge of the terms, but there's one room where the babies are in cribs and there are other dormitories for the mothers. There's also an older woman, when I visited them, supervising the entire ward. But, it was a very nice setting during a very important period of time in the life of a mother and the child.

Thank you, Mr. Chairman.

Mr. HUGHES. The Chair recognizes the gentleman from Illinois.

Mr. SANGMEISTER. Thank you.

I think this is probably best directed to you, Doctor, because I've had one or two inquiries concerning this. Suppose for purposes of discussion there's a diagnosis made by you or your staff that an inmate, say, would have prostate cancer, and your decision is it's not that bad; it probably ought to be left alone, nothing else done. The inmate, in discussing that with his family who has then discussed

it with the family doctor, feels that the prostate gland, for example, should be removed. There's a difference of opinion.

Further, let's say that the family is willing to take care of all costs and have the family doctor do it. How is that situation resolved, or do you attempt, then, to work with the family and say, if that's what the inmate wants, what the family wants, we'll accommodate, or how is that handled?

Dr. MORITSUGU. We do take into consideration what the inmate is interested in doing and what the family has requested. However, there is, again as you are aware, a statutory responsibility that we have to provide the care as well as the custody for these individuals.

There have been occasions where the inmate patient has disagreed with the opinion of one of our health care providers. Unfortunately, the individual does not have the flexibility to walk to another health care provider down the street, as it were.

But, in those kinds of circumstances where it has been documented that the inmate may be requesting a second opinion, we do have access to consultants from the community where we would certainly attempt to address that. Now, clearly, we're not going to be addressing every single request for a second opinion, but I think there is clearly a professional judgment call, if there is a question, as to the appropriateness of this or that kind of a diagnosis and a procedure.

The example that you give would not occur because if an individual had, in fact, prostate cancer, the indication, the absolute medical indication, would be the removal of that.

Mr. SANGMEISTER. Well, maybe my example was a bad one, but what I'm really trying to get at is what kind of cooperation you have with the inmate's family when they're concerned that you're not proceeding as they think some other doctor would.

Dr. MORITSUGU. Well, I will tell you, sir, that we do receive communication on a regular basis from many families who are questioning the type and the amount of care that we are providing, and each of these is reviewed on an individual basis. We try to resolve the issue at the local institution level. If it is not resolvable there, the individual patient or the family has recourse to requesting further review at the regional level and personal review by me ultimately.

Mr. QUINLAN. If I could add to that, Congressman Sangmeister, the Bureau of Prisons also has statutory authority to grant medical furloughs. We do on occasion grant medical furloughs for the type of case that you were describing where there's no essential medical treatment needed; it's the medical judgment of the prison provider and maybe the outside consultant that there's really nothing that needs to be done, but the prisoner and/or his family really want to have it done.

We have two ways to do it actually. We can do it through a medical furlough at the prisoner's expense. All costs are borne by the prisoner and/or his family, or we could do it under an escorted trip where the additional cost would have to be borne for the supervision and the security of the prisoner. These types of cases actually, Congressman, are very, very rare. Generally, when they do occur, I get personally involved in them because they generally in-

volve people of some substance who have substantial contacts on Capitol Hill and other places around the country. But, they are very rare.

Mr. SANGMEISTER. OK, getting to the question, I guess, that concerns us all these days, and certainly concerns you, and that's the subject of AIDS. It was a national commission that made the recommendation that there ought to be an education program in our Federal prisons regarding it. Has that been implemented or what are you doing in that area?

Mr. QUINLAN. We implemented a national education program in Federal prisons in 1987, Congressman Sangmeister, and the President's Commission recognized our education and our general program and the handling of AIDS as a model for the States to follow in terms of handling AIDS in prison. We have reviewed our educational materials recently and done a new videotape, as well as some other augmenting brochures. We have, I think, an excellent 30-minute videotape that is shown to every new prisoner. It's shown to every new staff member, and really conveys a very strong, important message on the way of handling that kind of a situation in a prison.

Dr. MORITSUGU. Let me add to that, Congressman—

Mr. SANGMEISTER. Yes.

Dr. MORITSUGU. We really do have a commitment to the education portion with regard to this epidemic, because we do not segregate our AIDS patients; we mainstream our AIDS patients. So, the fundamental premise of our entire management of the disease within our general population is education and not segregation. We have a very, very important component of our program which is focused on education, not only of staff, but also of inmates.

To give you a further example, in addition to the new AIDS video that we have just released, when the AIDS Quarterly was being produced by Public Broadcasting, we were able, through a licensing agreement, to obtain the Quarterly videotapes. We duplicated the AIDS Quarterly and sent it to all of our institutions for part of the education program.

Mr. SANGMEISTER. Those inmates that are diagnosed as positive—we hear about this AZT, a drug that seems to be of some help—how does that work under your system, or does it work at all?

Mr. QUINLAN. It works very, very well, Congressman. We provide AZT treatment to all offenders whose white blood count is at the level that would indicate AZT treatment. Those offenders who are identified as infected are monitored carefully and blood tests, et cetera, are done. Absolutely, we will provide the same quality of care that is available in the community. This is an example, I think a good example—even though it's a very expensive procedure, even though the results aren't yet documented and proven finally, even though we are providing it to Federal prisoners.

Mr. SANGMEISTER. I know you indicate that you don't segregate the population based on that, but how do you handle it with your correctional officers? Are they all fully aware of who's carrying or would have the virus or actually have AIDS?

Mr. QUINLAN. No. No, sir, we do not tell anyone other than the health provider. The chief medical officer will tell the warden and

the chief correctional supervisor. No other disclosure of that information is permitted within the prison. The reason for that, Congressman, is that our education program in terms of infectious diseases is based on one premise, and that is, to assume that every person you come in contact with is infected. It would be bad practice if staff and/or inmates start thinking that this one is infected and this one isn't, when we all know that no one really can tell for sure—sometimes the incubation period is as long as 14 months before a positive blood test will demonstrate that you are infected. So, we take the position that everyone's infected and act accordingly. That's why we don't tell anyone.

Mr. SANGMEISTER. Thank you.

Mr. HUGHES. The gentleman from North Carolina.

Mr. COBLE. Thank you, Mr. Chairman.

Gentlemen, it's good to have you all with us today.

I want to talk just a minute, Mr. Chairman and gentlemen, about cost containment. Now it's my belief, fellows, that there's probably not a Federal entity or Federal agency that is operating as tightly as it could—the Bureau of Prisons, the Federal judiciary, the Public Health Service, the FBI, the Congress of the United States. I think we all could be more fiscally prudent than we are.

I see from your statement, Mr. Quinlan, that in the decade just concluded, the Bureau's costs associated with medical care for Federal prisoners rose from \$4.1 million to \$41 million. That's a sizable increase. Now I realize there has also been an increase of inmates reflected in these numbers. The complexity of medical problems also, no doubt, has contributed to this obvious increase in costs.

My question, I guess, is: what can we do—and, of course, I'm not sure that the Congress is a paragon of virtue when it comes to fiscal austerity. I guess what I should say is maybe we should apply the old adage: don't do as we do; do as we say. But, is there anything that we can do to assist you as far as cost containment?

Now we've talked about physician assistants today as opposed to licensed physicians or licensed practitioners of medicine. I know there have been some folks who have been critical, Mr. Quinlan, because there's not always a licensed physician on board. I think when an inmate needs the attention of a licensed physician, surely that should be in order. But, I think probably in many instances a physician's assistant could very well serve the role just as well. My question is a circuitous one, but having said all that, can we do anything to help as far as containment of costs?

Mr. QUINLAN. Well, Congressman Coble, that is an excellent question, one which does not have easy answers. The Bureau of Prisons has expended 10 times the amount of money for outside medical costs, as you indicate, for primarily the reason of increased population, but also because the state of the art, as you indicate also, in medical practice has increased. The MRI's and the CAT scans and all the very sophisticated equipment are not inexpensive to acquire, either through purchase and/or through a consultant contract.

The state of paranoia, I think, among medical practitioners in the community has dramatically increased over the last decade, so that—because of malpractice concerns and other concerns—the interest of the physician sometimes is to triplecheck when a

doublecheck would have been sufficient. So, I think the problem is very, very significant.

We use health professionals to the extent we can, but, as you indicate, when you need to see a physician, you need to see a licensed physician. About 175 of our medical positions are physicians; and about 25 of them are vacant. If we can get better pay for physicians, maybe we won't have to spend so much money on consultant physician services. That is possibly one way we could approach it, but I appreciate and I applaud your efforts to reach a better solution and a more austere solution, but in the area of medical care it is a very elusive problem.

Mr. COBLE. One more question, and this is going perhaps to the other side of the coin. I note on the west coast, Mr. Quinlan, that there is only one facility, and that is a very limited one as far as availability of beds is concerned. It is a 13-bed facility. Do you find that adequate?

Mr. QUINLAN. Yes, Congressman. I should probably let Dr. Moritsugu answer this in more detail, but, generally speaking, since most of the medical care that we provide in the Bureau of Prisons is provided either in the institution or in a consultant capacity in the community—

Mr. COBLE. Right.

Mr. QUINLAN [continuing]. It is satisfactory.

Mr. COBLE. I figured that was the case.

Mr. QUINLAN. And then those cases that require long-term hospitalization come to a centralized facility in Springfield, MO, or Rochester, MN, as the primary places, or mental health cases to Butner, as you have visited—thank you so much—Butner, NC.

Mr. COBLE. Thank you, sir.

I don't know, Mr. Chairman, whether you've been to Butner or not—

Mr. HUGHES. I have not been.

Mr. COBLE [continuing]. But, as the Director said, I did visit Butner, I guess a couple of years ago—

Mr. HUGHES. That's great.

Mr. COBLE [continuing]. And that, too, was a very meaningful visit. The Chair, if your schedule permits, may want to include that in your itinerary.

Thank you, gentleman.

Mr. QUINLAN. Thank you, sir.

Mr. HUGHES. In fact, we talked about visiting Butner a number of years ago when I visited Marianna and Atlanta. So, that's a facility that we can perhaps look at sometime.

I've got a lot of questions, and I want to try to move it along. We have a vote in progress. The Springfield Medical Center has been the focus of some controversy. What is the status of the civil rights investigation of the December 1990 death at the Springfield Medical Center?

Mr. QUINLAN. The Civil Rights Division reported earlier this week, Mr. Chairman, that the investigation is still ongoing. When we turned this over to the Civil Rights Division initially, a day or two after the occurrence of this unfortunate death, it was not our understanding that it would be so time-consuming, but it's a very

difficult case. I can understand their taking sufficient time to really study it carefully.

Mr. HUGHES. What was the cause of death? Do you know?

Mr. QUINLAN. The cause of death, according to the autopsy, Mr. Chairman, was a heart attack.

Mr. HUGHES. What steps, if any, have you taken in response to that particular situation to assure that in the future, similar deaths do not result?

Mr. QUINLAN. Well, one of the first steps that we took to ensure that our procedures on using force, which is something we hold very, very sacred because we do not want to abuse the authority that has been vested in us by Congress, is the message that we have reiterated to our staff: The importance of paying close adherence to our policy on the use of force. When that policy is followed as it should be, generally speaking, there will be no problems; no one will get injured, and we'll be able to contain the problem quickly and efficiently.

So, the major defense to these kinds of situations occurring, Mr. Chairman, is a reemphasis of a longstanding Bureau policy on the appropriate use of force.

Mr. HUGHES. There's no question in that instance that the death perhaps could have been avoided—in that instance?

Mr. QUINLAN. There is no doubt in my mind that the result of that incident was not intended. There is no doubt in my mind that we should use every effort possible to find alternatives other than using force. When we use force, there are possibilities that untoward events can occur.

Mr. HUGHES. Now that particular episode was videoed, was it?

Mr. QUINLAN. Yes, it was, Mr. Chairman.

Mr. HUGHES. OK. So, the video is available?

Mr. QUINLAN. Yes, it is, sir.

Mr. HUGHES. What's the current status of the surgical department at Springfield?

Mr. QUINLAN. The surgical department in Springfield about 3 months ago stopped doing operations that required the use of general anesthesia. The reason for that is during the Joint Commission on Accreditation of Health Care Organizations audit of the facility for its renewal of its longstanding accreditation, they determined that our backup emergency system was, in effect, irregular, or it could be if there were an emergency situation. Not only would the primary electrical system go out, but it's possible that the secondary backup system would go out simultaneously. We just learned that.

For that reason, we have stopped doing surgery which requires general anesthesia in the institution, which represents about 40 percent of the surgery that we previously did at Springfield. We're now doing all of that general anesthesia surgery at a local hospital. No delay or irregular treatment results for an inmate. It's just a different venue than we would otherwise have for some of the surgery.

Mr. HUGHES. The National Prison Project, of the ACLU, indicates in written testimony, that will be produced today, that patients diagnosed with mental illness worked as ward attendants for

inmates at Springfield; is that the case? Does that practice continue?

Mr. QUINLAN. Mr. Chairman, it did occur at the Springfield facility for many, many years. When it was called to my attention about a month or so ago, when I received a copy of a letter that had been mailed to you from the ACLU, I asked that the Springfield facility stop the practice, not that it wasn't—and I'm trying not to be defensive here—not that it wasn't a very therapeutic policy that allowed the individuals who were involved as inmate attendants to feel as though they were doing something worthwhile, because what they were doing wasn't really high-level work; it was basically orderly work, feeding patients who couldn't feed themselves or assisting a licensed practical nurse to turn a patient or change the linen or clean the room or empty the bedpan, and things of that nature. They were fairly menial types of chores, and for the offenders from the mental health unit who were in a stage where they could tolerate that kind of interaction with other people, it was an extremely positive experience for them.

But quite honestly, because of public attitude and the appearance that this may not be appropriate for prisoners recovering or being treated for mental illness, that they should be around inmates receiving other medical care, we stopped the practice. We still have inmate attendants who are not mental health patients, though. Twenty-six inmates at Springfield today continue to work as inmate attendants in those types of attendant positions that do not involve direct patient care.

Mr. HUGHES. There's a vote that's in progress. I suspect it may be followed by another vote within 5 minutes. So, we're going to recess for about 15 minutes.

[Recess.]

Mr. HUGHES. The subcommittee will come to order.

Mr. Director, the last question dealt with the National Prison Project, and your response was that it's an ongoing investigation. I have a couple more questions about Springfield. I also have a number of other questions, some of them I will ask you now, and the others I will submit to you in writing because we're running behind schedule. While we have some time now, I want to cover some ground before I excuse you because I know you have other commitments.

We have what, six or seven psychiatric vacancies at Springfield?

Mr. QUINLAN. We have seven psychiatric positions, Mr. Chairman, at Springfield. Currently, we have one position filled, two more to be filled in the next month or so. One of the positions is being occupied temporarily by a psychiatrist from another Bureau of Prisons institution, and we have another position filled by a contract consultant psychiatrist. So, at this very moment, we have three out of the seven psychiatrist positions filled. Shortly, we will have one more, and hopefully before too much longer we will have all seven positions filled.

Mr. HUGHES. If I understand you, we have one permanent position filled and six vacancies?

Mr. QUINLAN. Yes sir, in terms of a full-time psychiatrist, that is correct.

Mr. HUGHES. Yes. You've attempted to fill some of the vacancies with temporary appointments in two instances, and hopefully you'll have another one on board, but for the present time we have six vacancies?

Mr. QUINLAN. That's correct. That's correct.

Mr. HUGHES. OK. How many deaths were there at Springfield this past year?

Mr. QUINLAN. In fiscal year 1990, Mr. Chairman, there were 156 inmates who died at Springfield—

Mr. HUGHES. OK.

Mr. QUINLAN [continuing]. Many of whom died as end-stage AIDS cases.

Mr. HUGHES. How many autopsies, post mortems, did we do?

Mr. QUINLAN. I'll supply that for the record, Mr. Chairman.

[The information appears in the appendixes.]

Mr. HUGHES. Did we do, as a matter of course, autopsies?

Mr. QUINLAN. As a matter of course, any time when the cause of death is not certain, we provide—we have statutory authority to mandate an autopsy.

Mr. HUGHES. I know that you have statutory authority, but do you conduct autopsies as a matter of practice?

Mr. QUINLAN. I believe we do. I don't want to misstate, so I will check and send it for the record.

[The information appears in the appendixes.]

Mr. HUGHES. A district court in Texas recently held that a doctor at Springfield had provided care for an inmate, Ronnie Holly, that was below the standard of community care. First of all, is the doctor still with the Bureau of Prisons and, if so, in what capacity?

Mr. QUINLAN. Yes, the doctor is still with the Bureau of Prisons. He is the chief of surgery at the Medical Center for Federal Prisoners in Springfield, MO. Despite a comment that was made during the opening remarks, Mr. Chairman, I don't believe that the findings of the court necessarily documented or proved that the doctor was not qualified to do the surgery that was performed. It is our belief, and certainly my belief and understanding, that even though he is trained in osteopathy, that he is qualified and permitted to perform the type of surgery that he undertook.

The result was not the result that was intended. Certainly, we're not pleased that the untoward surgical result occurred. I'm sorry for the pain and suffering that may have been undertaken by the prisoner and, as I've indicated before, it's an indication of the fact that we still have not reached the level of perfection that every person might want. But, I don't believe the case is any different than you would find in a community health facility, a community hospital. The results are sometimes—I think the last report I read is that 4 percent of all hospital admissions in this country, not in prisons, 4 percent of all hospital admissions in this country result in unintended results. We, I think, are no worse than that particular statistic.

Mr. HUGHES. I take it you dispute the decision of the court? You're reviewing it for appeal? Is that—

Mr. QUINLAN. No, for other reasons, Mr. Chairman, we are not going to appeal the case. I do not quarrel with the judge's finding. What I quarrel with is the characterization of the doctor not being

qualified to do the surgery. I only believe that the result was not the result that was intended and, therefore, the inmate is entitled to compensation. But, to say that the doctor was unqualified to do the surgery I believe is an overgeneralization of the situation.

Mr. HUGHES. Well, the court found that the treatment was below the community standard—

Mr. QUINLAN. Yes.

Mr. HUGHES [continuing]. In that instance? OK.

Mr. QUINLAN. That's correct.

Mr. HUGHES. Do you require that physicians be licensed by the State in which they are practicing? I know you testified that in some instances physicians were licensed to practice in several States, but my question is, are they required to be licensed in the State that they're practicing?

Mr. QUINLAN. No, the Federal Government, not just in the Bureau of Prisons, but the Federal Government does not require of its doctors or its lawyers or other professionals that they be licensed in the particular State in which they are practicing. They must be licensed. Under the current rules they must be licensed, but we would be greatly limited in our ability to send people to other facilities if they could only practice in the licensing state. For example, we're sending a psychiatrist on temporary duty to Springfield to fix a problem. He's not licensed in the State of Missouri, but he is qualified as a psychiatrist, licensed as a psychiatrist, and probably board certified as a psychiatrist. I think that that is reasonable under the circumstances.

Mr. HUGHES. All physicians in the system are licensed?

Mr. QUINLAN. All physicians in the Bureau of Prisons, both those serving as Public Health Service physicians and all civil service physicians who are providing direct patient care, are licensed.

Mr. HUGHES. What are the requirements for an individual to be licensed or hired as a physician's assistant?

Mr. QUINLAN. There are two major categories, Mr. Chairman, of people that we hire as physician assistants. One are those who are graduates of accredited physician assistant educational institutions. That represents a good portion of the physician assistants that we employ.

There is another category that is made up of people who are graduates of foreign medical schools who come into the Bureau of Prisons without certification as a physician because they are not licensed in this country to practice medicine, but they are good, quality health providers. We employ them as physician assistants. They are not, however, certified as physician assistants in the sense that the physician assistants who graduated from accredited educational facilities are certified.

Mr. HUGHES. What initial training and continuing education do doctors, nurses, and physician assistants receive?

Mr. QUINLAN. Could I ask Dr. Moritsugu to respond to that?

Mr. HUGHES. Sure. How does that compare with what others receive in the community?

Dr. MORITSUGU. The initial training of our health care providers, Mr. Chairman, is an intensive period, an introduction to corrections at our Federal Law Enforcement Training Center in Glynco, GA, augmented by an institutional familiarization program. The indi-

vidual health care providers receive orientation to correctional health care. This is an area that we are very concerned about and already have both programs in place and plans to extend training significantly. Such training will include a mentoring program for a brief period of time prior to putting that individual into the direct role of a practitioner or provider of care.

Subsequent to the initial employment, we do have a program for continuing professional education by which each health care provider receives a continuing professional education allowance. This year I believe it's somewhere in the range of \$1,200 per physician, plus administrative time of approximately 1 full week per year to obtain continuing professional education.

This continuing professional education extends not only to the physicians, but also to physician assistants, dentists, pharmacists, and other health care providers within the system.

Mr. HUGHES. Twelve hundred dollars? Does that include transportation?

Dr. MORITSUGU. Yes, it does.

Mr. HUGHES. So, it's \$1,200 plus transportation?

Dr. MORITSUGU. No, I'm sorry, it is \$1,200 including transportation. That is the total allowance.

Mr. HUGHES. That hardly seems like a lot of money to travel to some university setting for continuing education. How many physicians avail themselves of that?

Dr. MORITSUGU. At last count, sir, the average was approximately 75 percent last year that actually availed themselves of the continuing professional education. I will tell you that, as we continue to try to focus on this, we are looking at making continuing professional education not only a benefit of employment, but also mandatory and targeted. We will be doing a needs analysis, depending upon what we find as prevalent diseases within the institutions, where there may need to be additional education and skills and training, and then creating that as a mandatory focus for continuing professional education.

We do two things along these lines. One, we allow the individual health care providers to select, as professionals, those areas that they feel they need to have continuing professional education. We also have a secondary program by which we bring together on a regular basis groups of individuals for programs that we design and that we actually conduct. These programs are accredited, either directly or through some of our affiliate organizations.

Mr. HUGHES. Do I understand that you may modify the program to encourage physicians to receive additional training in the areas that will assist them in doing their jobs as opposed to continuing education programs that might not be of specific assistance?

Dr. MORITSUGU. You're correct, sir. That's what I'm saying.

Mr. HUGHES. Well, again, \$1,200 doesn't seem like a lot of money. Registration fees are often \$400 and \$500 in some of the professions I'm aware of. So, they end up paying the balance out of their own pockets; is that what—

Dr. MORITSUGU. It either comes out of their pocket, sir, or at the institutional level, the institution does augment what is provided at a national level. I do need to put this into context, sir. While the attempt may appear to be inadequate on an individual basis,

when you start adding all of this together, it starts getting to be a rather large sum.

I would certainly advocate as much as we can—this is a balance between what the budgets need to be expended—

Mr. HUGHES. Maybe you can furnish for the record—I'm not going to ask you today because I'm sure that information is not readily available, but I'd like to see a breakdown on the number of physicians and their particular disciplines—psychiatrists, surgeons, and so forth—that availed themselves of continuing education this past year.

Dr. MORITSUGU. Certainly.

[The information appears in the appendixes.]

Mr. HUGHES. Do you have any working relationships with any medical schools around the country?

Dr. MORITSUGU. We do have working relationships with several academic health science centers, including medical schools around the country. Our medical center in Rochester, MN, for example, is directly affiliated with the Mayo Clinic, and we obtain a significant amount of our consultation and services through the Mayo Clinic and its affiliated hospitals.

At our medical center in Lexington, KY, we are in the process of expanding our relationship with the University of Kentucky Medical Center. All of our institutions, in fact, have been encouraged to reach out into the local communities to identify training programs, such as physician assistant training programs, nurse training programs, and training at other medical centers to provide this additional quality input.

Mr. HUGHES. In your siting of new medical facilities, do you take into account the proximity of the medical centers, like Mayo, for instance? Rochester would seem to be an ideal location because of its proximity to the Mayo Clinic, one of the finest probably in the world.

Dr. MORITSUGU. In fact, Mr. Chairman, what we are looking at is a projection in terms of what our bed needs will be into the 21st century. To that end, there is a long-range facility plan which would involve our constructing several hundred new beds over the next several years. Part of the criteria that we have articulated for the siting of those institutions is that they would be part of correctional complexes, so that we would have capabilities of stratifying our health care, providing efficient health care across a large number of our population, but also siting those institutions in medical marketplaces where recruitment, retention, and maintenance of quality of care would be augmented by its geographic location.

Mr. HUGHES. Do you encourage the medical staff to develop affiliations with teaching hospitals?

Dr. MORITSUGU. Yes, we do, sir.

Mr. HUGHES. I see. How many doctors does the Bureau of Prisons employ today?

Dr. MORITSUGU. I believe the number is around 150 right now, sir. I'll have to insert that for the record.

[The information appears in the appendixes.]

Mr. HUGHES. I believe the Director indicated that 25 percent vacancies exist—

Mr. QUINLAN. Twenty-five physician positions.

Mr. HUGHES. Twenty-five positions.

Mr. QUINLAN. Approximately 25 out of a total of 175 positions.

Mr. HUGHES. Twenty-five vacant?

Dr. MORITSUGU. The actual percentage, sir, is in the range of 16 percent for physician vacancies. This is in comparison to approximately 2½ years ago where, across the board in all of our health care positions, we were approximately 25 percent vacant. We are currently less than 10 percent vacant, and we have been so for the last 2 years.

Mr. HUGHES. Which are the hardest disciplines to fill?

Dr. MORITSUGU. Psychiatry positions, psychiatrists—

Mr. HUGHES. First?

Dr. MORITSUGU [continuing]. As a subset of physicians in general, physicians in general, and physician assistants is the third category.

Mr. HUGHES. Mr. Director, have any steps been taken to investigate the allegations made in the Dallas Morning News and the recent Washington Post article? You've also alluded to "Sixty Minutes." Have you looked at any of those allegations?

Mr. QUINLAN. We've looked at all of them, Mr. Chairman.

Mr. HUGHES. OK. And, what have you concluded?

Mr. QUINLAN. Well, I think, generally speaking, the articles and the video portrayal on "Sixty Minutes" picked isolated cases that were not outcomes that were intended. "Sixty Minutes" generalized from those isolated cases to an inaccurate conclusion that these kinds of conclusions or unintended results occur all the time or in a high percentage of the cases. In fact, looking at all of our lawsuit cases and also all of our complaints from prisoners through administrative remedies and other types of claims that are filed, I firmly believe—and I think this is not just my belief as the Director of the Bureau of Prisons; I think this has also been found by others who have looked at this issue from a balanced perspective—that we provide quality care commensurate with community standards. We're not perfect. We're working toward improving our operations. We're going to find a better way to do it. We're hopefully going to find a more cost-effective way to do it. We're going to keep working on it. It's one of our highest priorities.

Mr. HUGHES. The gentleman from North Carolina.

Mr. COBLE. [Mr. Coble indicates he has no questions.]

Mr. HUGHES. Let me, if I might, ask about quality assurance programs, peer review. Just briefly, if you could Doctor, walk me through it. What is the structure and the process to review an outcome where there is perhaps some question about the medical procedure that was involved or the care that was provided?

Dr. MORITSUGU. Let me put it in the context, Mr. Chairman, that we are continuing to improve and refine our quality assurance program. In the past we have had quality assurance components, but there have been some components that were not to our liking in terms of the intensity and the level that we should be at.

We have had in the past a structure and a process review by which, through our Program Review Division, as well as through teams of internal reviewers, we have reviewed the activities at various institutions. We also have, on an ad hoc basis, where there are deaths or cases where an untoward outcome has been identified, a

process where we identify teams of both internal staff and external consultants to look very specifically at those situations and to provide us with their findings and their recommendations.

We are expanding the quality assurance activities for our general institutions to include outside consultants. In fact, just recently, within the last couple of months, we held our first quarterly death review in which we had representatives not only from the institutions, but also a consultant from an academic health science center review through a specific peer review process all of the deaths over a quarter.

Mr. HUGHES. The gentleman from North Carolina.

Mr. COBLE. Thank you, Mr. Chairman.

This question perhaps could be asked more timely later, but with our day being uncertain as it is, I'll ask it now. Mr. Quinlan, in her statement Dr. Thorburn maintains that, "Ideally, prison quality assurance programs should include both internal and external monitoring systems." My question is, Does the Bureau have any procedures in place for external monitoring of the delivery of medical care?

Mr. QUINLAN. Congressman Coble, and I think maybe Dr. Moritsugu is better qualified to answer this. My perspective on it is that certainly the Bureau is very open to being evaluated in these kinds of situations by professional organizations. The Joint Commission on Accreditation of Healthcare Organizations reviews our medical facilities. The Bureau is subjected to accreditation standards in the health care area as well as in other areas by the American Correctional Association. The Bureau conducts internal program reviews that have typically been done by Bureau of Prisons personnel, but we're also subject to the General Accounting Office and the Office of Inspector General for the Department of Justice, and we're inspected by other groups, State and local regulatory groups.

As Dr. Moritsugu answered or indicated during his previous answer, though, the medical staff of the Bureau is now integrating into the peer review process the expert opinions of outside physicians. As I mentioned during my statement as well as during some of the questions, a great deal of the medical care provided to Federal prisoners, particularly in the more complicated cases, is being provided by outside medical consultants. They're not public servants. They're outside medical consultants. We paid, as you indicated, \$41 million last year for that type of medical care.

We do have a lot of people looking at us, but maybe we could ask more people to look at us, if that would be in keeping with the concerns of the public and the Congress to be beyond a shadow of a doubt as to the quality of care that we are providing.

Mr. COBLE. Well, I think, Mr. Chairman and gentlemen, that might be symbolically important at least. You know, if you have someone from outside the loop endorsing your delivery as favorable and sound, that probably would be more impressive than someone inside the loop patting themselves on the back.

Mr. QUINLAN. I would certainly agree with that, Congressman Coble, so long as it is understood, I think by all the parties involved, that—you and I both know some of the people who would challenge our abilities in this area would like to pick the experts,

and I can almost see and I can almost visualize the report right now.

Mr. COBLE. And so could I.

Mr. QUINLAN. So long as there is coordination——

Mr. COBLE. Some sort of objectivity?

Mr. QUINLAN [continuing]. And objectivity, sir; yes, sir.

Mr. COBLE. Thank you. Thank you, gentlemen. Thank you, Mr. Chairman.

Mr. HUGHES. I have a few more questions. Doctor, I'm interested—in the context of peer review and quality assurance programs, and so forth—in the line of command from headquarters into the institutions. Is there a direct line of authority from your office, as the head of medical services for the prison systems, down into the system itself, the director of the particular facilities, medical care unit?

Dr. MORITSUGU. There is a——

Mr. HUGHES. What is that line of command?

Dr. MORITSUGU. There are two lines of command, if I might characterize it in this fashion, sort of a matrix management. There is the principal, day-to-day administrative line of command which winds up at the institution in the hands of the chief executive officer, the warden, who is ultimately responsible for the day-to-day safe operation of the institution. That includes within the warden's purview all of the programs within the institution, including the health services program.

However, there is also another line or chain of command, as it were, and that is a professional chain of command. As the Medical Director, I have responsibility for establishing, evaluating, and continually refining the policies and practices that will go on within the institutions, which then establish the baseline which is expected to be carried out on a day-to-day basis.

If you are asking me the question, "Do the physicians report to me on a day-to-day basis," the answer is, no, they do not. They report to the chief executive officer at the institution.

Mr. HUGHES. But, your office decides policy?

Dr. MORITSUGU. That is correct.

Mr. HUGHES. And that policy is disseminated to the various institutions?

Dr. MORITSUGU. That is correct, sir.

Mr. HUGHES. And, they report directly to you?

Dr. MORITSUGU. As far as policy is concerned?

Mr. HUGHES. Policy.

Dr. MORITSUGU. As far as how policy would be interpreted and carried out, yes, but from an operational standpoint, they would report to the institutional chief executive officer.

Mr. HUGHES. See, what I'm getting at is that we have a myriad of problems in this institutional setting. I think many of the problems you experience are because you have a very difficult environment in which to attempt to provide professional services. I mean, the physician-patient relationship is strained to begin with; it's very difficult. The physicians are called upon to be corrections officers of one type or another, or at least they get training at Glenco, I presume, in being a corrections officer as well as being a health care provider. So, that aspect of it is strained.

And, I'm trying to find out, in providing medical services, is there a clear line of command from headquarters, your office, right down into a medical facility, or is the head of that medical facility pretty much semiautonomous? That's what I'm trying to find out.

Dr. MORITSUGU. To use your term of being "semiautonomous," the clinical director at a specific medical facility is semiautonomous, but within specific parameters. The parameters would be, No. 1, that on a day-to-day basis the individual reports to the warden. No. 2, the individual does have limitations, and that is that there are specific policies that have been promulgated by the central office that the individual is guided by.

But, to say that the individual is following—and I don't say this in any negative sense—"cookbook medicine,"—that is not the way that we handle it. We do depend upon the professional judgment of the individuals.

Mr. HUGHES. Does it present a problem from time to time that you basically have a semiautonomous unit? You know, we're all professionals of one type or another, and does that present a problem? We have, first of all, a setting where the medical director of a particular facility is answerable to the warden. That in itself basically creates, I suspect, some pressures from time to time, because a warden's problems are a lot broader than providing medical care. By the same token, you have a professional operating as the chief medical officer of a particular facility with policy being set in Washington. Is there a line of command, or does that create some problems from time to time in attempting to carry out overall general policy?

Dr. MORITSUGU. I would answer that in this way, sir. While again there will always be problems in one or another area, in the 3½ years that I have been Medical Director for the Bureau, I have not had an instance where, if there were a dissonance between the chief executive officer and the clinical director, that the difficulty was not resolved. The reason is that, if there is a problem from a line, day-to-day management standpoint that the professional cannot resolve with the chief executive officer, that line professional also knows that there is a direct line of communication to me. I do receive phone calls along these lines. When that occurs, as an Assistant Director of the Bureau, I also have venue or contact with the chief executive officer, and we are able to work out those differences.

Mr. HUGHES. Does the Bureau of Prisons have any protocol regarding when a patient is seen by a doctor after having been seen by a physician assistant?

Dr. MORITSUGU. There is a protocol that way, yes, sir.

Mr. HUGHES. And, what is that protocol?

Dr. MORITSUGU. The protocol is that the physician assistant is the principal health care examiner and provider within the system under the direct supervision of a physician. The physician assistant will make the determination as to whether or not the individual patient inmate needs to be further evaluated by the physician or whether or not, as is normal community practice, the physician assistant may make determinations within specific set protocols and report the evaluation, as well as the action, to the physician for concurrence.

Mr. HUGHES. What medicines can a physician assistant prescribe?

Dr. MORITSUGU. The physician assistant basically can prescribe the full range of the medications that are available within the institution. The requirement is that the supervising physician review the charts and actually sign off on them.

Mr. HUGHES. Finally, just picking up on something the gentleman from North Carolina got into a colloquy with the Director about, insofar as outside peer review, I take it that you have an open mind on that subject?

Dr. MORITSUGU. That's true, Mr. Chairman.

Mr. HUGHES. Your willingness to take a look at this issue would contribute to the overall credibility of the system. I think that that is something that we need to look at.

Dr. MORITSUGU. OK, we'll do that, sir.

Mr. HUGHES. Yes. I have some other questions, but time is running out on us. The Marshals Service is getting very nervous. So, we'll direct some additional questions in writing to you.

[The information appears in the appendixes.]

Mr. HUGHES. We thank you for attending the hearing today, your cooperation, and, in particular, your openness and your willingness to work with the committee and others to try to fashion the very best system.

As I said in my opening statement, I think overall you do a good job. If we can do better, we need to do that. If we have problems, we need to look at the problems and admit they're problems and then move to try to solve them. I think that's the approach you've taken. I think it's commendable. Frankly, I agree with you wholeheartedly: probably most of the inmates that you see in your facilities get far better care than they ever got in the private sector. I agree with that.

OK, thank you very much.

Mr. QUINLAN. Thank you very much, Mr. Chairman.

Mr. HUGHES. We appreciate your testimony.

Mr. QUINLAN. Thank you, Congressman Coble.

Mr. HUGHES. I'd like to welcome our second panel of witnesses this morning, three Federal prisoners who have personal experiences with the Bureau's health care system: Mr. Sidney Mayley, who is accompanied by his attorney, Mark Streed; Mr. Herbert Blitzstein from the medical center in Rochester, MN, and Mr. Rinaldo Reino who is from the Medical Center for Federal Prisoners in Springfield, MO.

Gentlemen, I appreciate your willingness to come forward today and testify. I know that it's with some degree of apprehension on your part, but let me assure you that I know that your fellow inmates will appreciate any insight that you can provide us on medical care in the prison systems. So, we welcome you here today.

Mr. Mayley, why don't you begin and tell us a little bit about you, where your home was, why you're in prison, and then a little bit about the medical care in the prison system?

STATEMENT OF SIDNEY MAYLEY, PRISON INMATE, ACCOMPANIED BY MARK D. STREED, ATTORNEY, MESHBESHER, SINGER & SPENCE, LTD., MINNEAPOLIS, MN

Mr. MAYLEY. I'm from New Orleans, LA. I'm doing a 25-year sentence for armed bank robbery.

Mr. HUGHES. Armed bank robbery? Can you speak up a little bit for us?

Mr. MAYLEY. I've been at the Federal medical center since September 1985. I've had approximately six operations since then. In my earlier months in there, I received a lump. When I came there for further evaluation, for months I was told that it was scar tissue, no concern, no concern.

Mr. HUGHES. This was in 1985?

Mr. MAYLEY. No, this was in 1986 at this time.

Mr. HUGHES. 1986.

Mr. MAYLEY. My consultations with the Mayo Clinic had ended, and the lump continued to grow. Then, all of a sudden, it's several months down the road and I'm cleared medically and I'm transferred out of the Federal medical center, back to my mother institution which was El Reno.

Six weeks after that I was returned to the Federal medical center, only to find out that I had to lose my jaw and my neck and go through extensive treatments just to survive. The doctors that treated me from the clinic still feel like I'm lucky to be alive today.

Mr. HUGHES. When did the lump first surface?

Mr. MAYLEY. It was in June 1986.

Mr. HUGHES. June 1986. And, who did you first consult?

Mr. MAYLEY. Dr. Jenson I believe was the doctor at that time.

Mr. HUGHES. And, that was at Springfield, MO?

Mr. MAYLEY. No, sir, that was at the Federal medical center in Rochester.

Mr. HUGHES. That was where?

Mr. MAYLEY. At the Federal medical center in Rochester.

Mr. HUGHES. In Rochester? And, what did they tell you there at the Federal center at Rochester? What was the cause of the lump?

Mr. MAYLEY. I was told that it's just scar tissue and don't worry about it; you'll be seeing the doctors downtown soon, Dr. Jackson, who was my treating physician.

Mr. HUGHES. Scar tissue from what, a previous accident?

Mr. MAYLEY. An operation. At Springfield I had rotating skin flap where they removed about three-quarters of my lower lip.

Mr. HUGHES. When had they done that?

Mr. MAYLEY. That was in early 1985.

Mr. HUGHES. In early 1985?

Mr. MAYLEY. Yes, March. And prior to that, I've had numerous operations from a private physician in New Orleans.

Mr. HUGHES. And, what was the nature of those operations in New Orleans?

Mr. MAYLEY. They've all been the same, squamous cell carcinoma.

Mr. HUGHES. The same condition?

Mr. MAYLEY. The same condition.

Mr. HUGHES. Carcinoma?

Mr. MAYLEY. All a form of skin cancer, yes.

Mr. HUGHES. I see. When did you first notice that you had problems with the side of your face? How many years before your first operation?

Mr. MAYLEY. It was a number of years before my first operation. As soon as I saw something, I always immediately would report it, especially since the first one. It was a sore on my lip. I was very concerned with that, and they—

Mr. HUGHES. When did the sore on your lip first appear?

Mr. MAYLEY. I believe it was 1981.

Mr. HUGHES. 1981? Where were you then?

Mr. MAYLEY. In New Orleans.

Mr. HUGHES. New Orleans?

Mr. MAYLEY. Louisiana.

Mr. HUGHES. You were not in prison at the time?

Mr. MAYLEY. No, not at that particular time, no.

Mr. HUGHES. I see. And that was the first indication you had any problem, when a sore appeared on your lip?

Mr. MAYLEY. Yes, sir.

Mr. HUGHES. Did you consult with a physician in the private sector?

Mr. MAYLEY. Yes, sir.

Mr. HUGHES. In New Orleans?

Mr. MAYLEY. Yes, sir.

Mr. HUGHES. And, what did he prescribe?

Mr. MAYLEY. He removed it, and approximately a year later it returned again. And, again, he removed it. After that it returned, and then I was in the prison system. His recommendation was to go to M.D. Anderson, and he showed all the reasons why, to receive the treatments, because the cancer was becoming aggressive, and we had no luck with that. We tried the furlough program; we tried—my family tried to pay the expenses of using the U.S. Marshals Service, the court system, anything, but we were denied that and sent to Springfield.

Mr. HUGHES. And, what year was that?

Mr. MAYLEY. That was in 1985 when I went to Springfield.

Mr. HUGHES. 1984. Where were you located, in what prison system?

Mr. MAYLEY. El Reno prior to Springfield.

Mr. HUGHES. The physician that performed the surgery, removed the lump on your lip, was he a dermatologist—

Mr. MAYLEY. A plastic surgeon.

Mr. HUGHES [continuing]. A medical practitioner? A plastic surgeon?

Mr. MAYLEY. A plastic—most doctors that deal with facial, head, and neck skin cancers are plastic surgeons. If you run into treatment programs, then you go into the oncologist department, but as far as the operations it's always been plastic surgeons in my case.

Mr. HUGHES. All right. Now, Mr. Streed, before I ask him more specifically about what he thought was good health services and what he thought was inadequate services, you indicated that you wanted to make a statement?

Mr. STREED. Yes, Mr. Chairman. As you indicated, Mr. Mayley—or maybe you didn't indicate this—there is pending litigation between him and the Bureau of Prisons. That lawsuit is nearing its

conclusion. Many of the issues and many of the points that you've touched on, numerous depositions have been taken, many motions have been brought to dismiss by the Bureau and the United States. To date, they've all been denied. But, the point is, all of this information is available to the public and, in fact, it's the U.S. District Court, District of Minnesota, the first division. The file number is 489929.

There are a lot of disputed facts involved in that litigation. In light of this status, some of those issues would best be kept in the court system and perhaps not fully discussed here, although much of it is in the public sector as far as records can be obtained, and it might be a good idea to see both versions, the Bureau's and Mr. Mayley's.

But, despite that, not really wanting to dwell too much on the specifics of his case, there are some general, many general observations based on his 7 or 8 years in the Federal prison system and all the medical care he's received and seen others get and not get.

Mr. HUGHES. Well, why don't we let him testify?

Mr. STREED. He would like to do so, and he would like to respond and help you with your mission, because he sees that as a potential help not only to himself, but more so for other people that are inmates right now.

So, with that, I'd like you to respect his situation and proceed from there.

Mr. HUGHES. All right. Well, thank you.

Why don't you tell us in your own words what you think was right about the treatment you received and where you believe you received inadequate care?

Mr. MAYLEY. Knowing that lumps and all were there, and they were recognized then in the medical records, everything was seen. The lumps were there. They realized they were lumps, and people wanted me to go see the doctors at the Mayo Clinic. The problem is I never did see these doctors. I never went. I was supposed to see these doctors on a 3-month basis, but I never went back. When the lump appeared, that was it.

Mr. HUGHES. How big a lump was it that appeared?

Mr. MAYLEY. It was the size of a jelly bean. It would get to that point. It would be the appropriate size.

Mr. HUGHES. The size of a jelly bean? On your lip, on the side of your face?

Mr. MAYLEY. No, on the left side of my neck, along the jawline.

Mr. HUGHES. The side of your neck? And—

Mr. MAYLEY. It resulted in—

Mr. HUGHES. On how many occasions did you go to the personnel there at the medical facility?

Mr. MAYLEY. It was a numerous thing. Whenever I would see them, I would ask them about it. I was very concerned with what—

Mr. HUGHES. What did they tell you?

Mr. MAYLEY. "Don't worry about it. You're going to go downtown. You're going to see Dr. Jackson. We're going to reconstruct your face. We're working on a program to save you, to fix your mouth," because it was damaged in the surgery in Springfield, to stop that

disfigurement. In the beginning I really believed these people were trying to help me.

Mr. HUGHES. How long did that go on before you finally received any care?

Mr. MAYLEY. Approximately 7 months.

Mr. HUGHES. About 7 months? How often did you visit the medical facility to ask about the lump on the side of your neck?

Mr. MAYLEY. In one form or another, at least once a week.

Mr. HUGHES. OK. Anything else you can tell us?

Mr. MAYLEY. The miscommunications as to the problems they see. People get an attitude against you and they say, "Well, you're complaining too much," so they avoid you. They walk away from you. You file paperwork, and they don't answer the paperwork. It's like they just want to hide these answers. They don't want to show you—no one wants to investigate, like you were talking about an open or an impartial party to investigate the system. That would be wonderful, even if the administrative remedies were investigated by someone besides the person that might be eating lunch with the guy you're filing against. You see answers that just don't make any sense. We've got no one to go to.

Mr. HUGHES. So, your answer is that you were able to get information and they did not provide the care that they promised you they would provide. You did not see a physician for 7 months. Is that the essence of—

Mr. MAYLEY. That's it.

Mr. HUGHES [continuing]. Of your complaint? Anything else that you can tell us? Do you have any general observations about the medical care you want to share with us?

Mr. MAYLEY. People go in there and they're afraid. You walk in the place now and you see a doctor and you say—in fact, the first question is, "Who's your doctor? Which doctor did you get?" And you can tell what your treatment is going to be like between which medical staff is treating you. If you get one doctor, you're going to get excellent treatment. If you get one doctor, his nickname is "Dr. Death or Killer Kemp," and there's all these other names, and you automatically get these fears. These doctors actually treat you like that.

You watch these people laying in hospitals, terminal patients, dying, laying there suffering. When you ask them why they don't give any pain medication, they tell them, "Well, we don't want you to have a drug habit." There's a lot of torture that goes on.

Mr. HUGHES. Don't you think that you'd have the same problem with that in the private practice with physicians? Doesn't it vary from physician to physician? That's why people choose one physician over another. Don't you have the same problem?

Mr. MAYLEY. I've been in the Mayo Clinic. I've been at both Methodists hospitals, St. Mary's Hospital, and I have about five physicians that have treated me for over 4 years now, and I've never seen any problems with any of them. There never have been any problems at all with any of our physicians downtown. I've never been treated like an inmate. I've never been treated like "I don't care if you live or die." I'm always been treated with respect and treated very well, cared about. If I'm hurting or receive pain

medication, I don't hear, "Well, I don't want you to have a drug problem, so I'm not going to give you that. I'd rather you suffer."

Mr. HUGHES. Well, thank you, Mr. Mayley.

Mr. Blitzstein, why don't you tell us something about your situation?

STATEMENT OF HERBERT BLITZSTEIN, PRISON INMATE

Mr. BLITZSTEIN. I was at the Federal prison camp in Boron, CA. I surrendered there in October 1987.

Mr. HUGHES. What were you charged with when you—

Mr. BLITZSTEIN. I was charged with tax evasion and credit card fraud. I have an 8-year sentence and I'm doing the maximum release.

Anyway, I got sick in January or February 1988, and I had trouble breathing quite a bit. So, I went to the physician assistant. They don't have a doctor at Boren, CA. They have a PA there. They do have a doctor, a contract doctor, that comes in once a week or once every 2 weeks, or whatever. I went to the PA on several occasions, and she told me, "You have a little flu or cold."

It got worse and worse. One day on a Sunday I was eating in the mess hall and the captain was sitting next to me, and he said, "You look very sick. I want you to go to the hospital." And I couldn't breathe very well.

They then took me to Lancaster Hospital in Lancaster, CA, where I was admitted immediately because I had pneumonia. While I was being treated for pneumonia, I had a cardiologist there, and he told me that I had a heart attack. I believe he called it a silent heart attack. His name was Dr. Yagani at the Lancaster Hospital.

They called a specialist in by the name of Dr. Yo, a lung specialist. He drained some fluid and made sure it wasn't malignant, so on and so forth. I had excellent care at the Lancaster Hospital.

The PA at Boron, CA, her name was Sandra Gutteratz. She told me because I was very heavy and that my lungs were smaller than normal people and I wasn't able to get any air. She was a woman of about 350 pounds. So, I said to her, "If I don't get any air, I don't see how you're breathing at all." She got mad at that, naturally.

I kept complaining that I was short of breath and she did nothing. By the way, the inmates call her "Killer Tomato" when she wears red. I was selected to a work cadre at Nellis Air Force Base in Las Vegas, NV. That's my home.

In August 1989, I had a breathing problem, and the warden there, John Dobre, took me to the Nellis Air Force Base Hospital. He had a choice to send me to the county hospital or a private hospital. He selected to put me in a private hospital, which saved my life.

I had a double bypass. The next day, by the way, I had a quadruple bypass. My heart filled up with blood about a day later, a day and a half later. I had a quadruple bypass after that. Two different surgeries.

I had some complications. I was given a drug called proamine, which is the opposite of heprine, and I developed some leg problems when they tried to take the veins in my right leg due to a

diabetic condition. Gangrene set into my leg and my foot. I was about to lose my leg until a plastic surgeon came in the picture.

I had several doctors at Valley Hospital, by the way. I had a doctor for internal medicine. I had a cardiovascular. I had a pulmonary doctor, a plastic surgeon, and an orthopedic. Now the Bureau of Prisons paid for all of this, by the way.

While I was in the hospital a doctor came down from Terminal Island and told the head doctor, which is Dr. Miller, in Valley Hospital that he looked into my records there and he said he was sent down from Washington. He looked at the records and he talked to my doctor and two nurses and told them that, "Well, it don't look like there's much good; just cut his leg off and send him back." That was his statement, by the way.

Mr. HUGHES. Who was he? Who was that?

Mr. BLITZSTEIN. I don't know. He was from Terminal Island. I don't have it with me. I had the—my lawyer has some records of that.

Mr. HUGHES. Was he with the Bureau of Prisons?

Mr. BLITZSTEIN. Yes. Yes, he was with the Bureau of Prisons.

After all this surgery, I was on my back for over 3 months, which I could understand the Bureau of Prisons was trying to get me out of the hospital as fast as they could because medical expenses in Las Vegas are very, very high, probably one of the highest in the country.

Finally, after x amount of time, about 3 months, they shipped me to FMC, Rochester. I was in very bad condition. By the way, this doctor from Terminal Island tried to get me released from Valley Hospital on several occasions, but the doctors at Valley Hospital would not release me because of my very poor condition.

When I got to FMC, Rochester in November, just before Thanksgiving 1989, I was sent there for therapy. I couldn't walk or anything. I had open sores or ulcers, whatever, on my leg, on my right leg, and I was in a very weak condition.

I waited around for about 4 or 5 months or so to get therapy at FMC Rochester. The therapist that was there at that time didn't do very much in the Bureau of Prisons. He had moved on to another station. The Public Health Service from Springfield prison came there on a weekly basis or semiweekly, like maybe 2 weeks at a time or 3 weeks at a time. They rotated from Springfield to FMC Rochester. Their names were Gene DiLolio, a fellow by the name of Wagner, and another one by the name of Hunt. They were excellent people.

They started my program of rehabilitation. Then after some time, FMC Rochester finally hired two fellows who are also with the Public Health Service. One's David Nester and the other one is Mike Flyzik. I mean, I just have the highest regard in the world for these people. They're caring. They want to help you. There's just no end to them. They've helped me—they really brought me back to life; I'll put it that way.

And, also, you know, I've been very lucky there. I didn't have one of the doctors that would push you aside. I had Dr. Canatella, who is very well known in the institution for her concern, and also Dr. Thompson. I developed another ulcer or infection in my foot, and

he had cut it out, and it's now healing. It's in a pin head stage. I'm on my road to recovery. And that's basically my story.

Mr. HUGHES. So, I gather—

Mr. BLITZSTEIN. In the beginning if it wasn't for the warden at Nellis, Mr. Dobre, and Mr. Van Tassel, I don't know what would have happened. On two occasions, I went into cardiac arrest at Valley Hospital. So, I guess I'm glad to be here right now.

Mr. HUGHES. So, I gather overall the medical care you received was pretty good? They didn't hesitate to get you to a private institution—

Mr. BLITZSTEIN. One more thing, Congressman: the PA at Boron, CA, took my heart medicine away from me. It was several months later when I had my severe heart attack. She eliminated my medicine completely. She said I didn't need it any more. She almost killed me.

Mr. HUGHES. So, just by way of summary, I gather, aside from—

Mr. BLITZSTEIN. Yes.

Mr. HUGHES [continuing]. Several things that the PA, the physician assistant in Boron, CA, did—

Mr. BLITZSTEIN. Yes.

Mr. HUGHES [continuing]. Such as taking your heart medicine away and her diagnosis—

Mr. BLITZSTEIN. Right.

Mr. HUGHES [continuing]. Of your small lung condition, and the complaint that somebody from Washington at one time was prepared to—

Mr. BLITZSTEIN. I have no other complaints.

Mr. HUGHES [continuing]. Forfeit your leg in the process, authorize them to take your leg away, that overall the medical care you received was good and that they provided excellent care, I take it, in the private sector where you were taken for your condition in Las Vegas?

Mr. BLITZSTEIN. Yes.

Mr. HUGHES. Any idea what the expense was in Las Vegas?

Mr. BLITZSTEIN. I believe it was in the hundreds of thousands.

Mr. HUGHES. Well—

Mr. BLITZSTEIN. I was there for 3 months and 3 days.

Mr. HUGHES. If you were in an institution for 3 months, I would assume it would be in the hundreds of thousands.

Mr. BLITZSTEIN. Yes. The exact amount I'm not sure.

Mr. HUGHES. I see.

Mr. BLITZSTEIN. I heard some figures, but I wouldn't say. I don't know.

Mr. HUGHES. Mr. Reino, we welcome you. I thank you very much, Mr. Blitzstein.

Mr. BLITZSTEIN. You're welcome.

Mr. HUGHES. Mr. Reino, welcome. Why don't you tell us a little bit about your situation?

STATEMENT OF RINALDO REINO, PRISON INMATE

Mr. REINO. Well, Mr. Chairman, mine ran with three different doctors, not just one. Mine started in Leavenworth, KS. I understand that there were over 1,000 inmates there at the time and

there were only three doctors there, but there were six or seven PA's there.

Mr. HUGHES. Why don't you tell us, first of all, why you're in prison, where you're presently located, and then you can tell us—

Mr. REINO. I committed a crime. I was guilty of it. I pleaded guilty and went to jail.

Mr. HUGHES. What was the nature of the offense?

Mr. REINO. Conspiracy to buy and sell narcotics.

Mr. HUGHES. Narcotics? OK. And, what kind of a sentence did you receive?

Mr. REINO. Fifteen years.

Mr. HUGHES. When were you sentenced?

Mr. REINO. I was sentenced—well, I was picked up September 26, I believe, in 1982. I was sentenced on January 25, 1983.

Mr. HUGHES. And you're about to be released from prison?

Mr. REINO. Yes, another couple of days.

Mr. HUGHES. I see.

Mr. REINO. What they call MR, mandatory release.

Mr. HUGHES. I see. Tell us a little bit about your condition, how it occurred, and the kind of care you received.

Mr. REINO. Well, I kept trying to get to see the doctor at Leavenworth, and his name was Barrowman, a young fellow, one of these doctors that they bring to pay off their loans, or whatever it is. He had just started to work there.

One day I was working in unit corps and I just couldn't take it any more. I fell down. The officer in unit corps picked me up, wanted to know what was the matter. I said, "I don't know. I can't sleep at night. My chest is killing me."

So he says, "All right, let me call a doctor to help take you over there," which he did.

They treated me for a cold. He said I had a bad cold and he was going to keep me in the hospital over the weekend because he couldn't give me the medication that he wants to give me in population. So, he put me in the hospital. That was a Friday afternoon.

Mr. HUGHES. What year?

Mr. REINO. 1983. Actually, I believe it was December 10, 1983, or December 7, one of them days; I'm not too sure of the date, Mr. Chairman.

And he gave me a pill. The night man come on with the paramedic that was working the hospital. He was an inmate at Leavenworth, but he was working in the hospital with the night man. He come in at 10:30 and gave me my other pill. By 12 o'clock at night, I had fallen out of bed. I fractured the fifth and sixth vertebrae in my neck. He never took any of the other medications away from me; he just kept adding it on. I was taking, I don't know, anywhere between 30 and 50 pills a week. I had three different kinds of squeeze breathalizers, whatever you want to call them; I don't know.

Instead of doing something or x raying, the paramedic that was there said there was something wrong with my neck. I'm laying on the floor. I fell out of bed, had a few little cuts on me. He says, "Don't move him until we strap him and get his neck right," which the kid was right; I had fractured the fifth and sixth vertebrae.

Anyway, they put me in the room next door. They started getting the doctor. They never done nothing until Monday afternoon. They never x rayed me. They never come in to see me. And then when I got to the hospital, someone, one of the lieutenants says, "He goes to the outside hospital now." I don't know who it is, Mr. Chairman. I can't remember his name. But, he said, "I don't care about procedures. You take this man to the outside hospital now."

Now I was in a coma. I don't know all of this that went on. This was all told to me.

When I was taken to the Leavenworth Hospital in that little town—I don't remember the name of it, but they refused me. He says, "This man is dying of pneumonia. Take him up to the Kansas City University Hospital," which isn't too far away. And that's where they saved my life. That was the first time.

When I woke up 8 days later, my wife was standing alongside the bed with my daughter-in-law, and she's telling me what happened and that I needed an immediate operation because I fractured the fifth and sixth vertebrae in my neck. I had caught a lung disease called histoplasmosis. I hope I said it right. And I've got pneumonia on top of it. This man is treating me for a cold.

But, anyway, they saved my life there with that. My wife says, yes, go ahead and give him the operation. She gave them all the insurance papers and signed everything. With that, a couple of marshals come in and said, "No, you can't operate on him. We've got to take him down to Springfield," which isn't too far from Kansas City.

I don't know all of this. All that I know now is that my wife is coming back in the morning at 9 o'clock. Well, it seems that the doctor who was on refused to sign any papers to turn me loose. And they came there at 8 o'clock the next morning with a warrant from the judge, whatever you want to call it, and took me out and brought me down to Springfield. I was in Springfield December 18, 1983. I've been there since.

Dr. Alback, who was a retired neurosurgeon, was working for them at the time, and he lives in the Phoenix area—excuse me, the Springfield area. He told me I had to get an immediate operation, too. He said, "But, we can't do it because the anesthesiologist says you cannot breathe on your own. We're going to have to wait."

Well, for 3 months I had a brace on my neck which they put on me in Kansas City when I was up there. I was doing fine. The pneumonia was over. I was taking baths, doing everything on my own; no problem.

They kept x raying, and finally after the third time, the 3rd month that they waited so long, he says, "Reino, I can't wait any more. We have to operate." He says, "The fracture is getting larger."

I said, "Do what you have to do."

Well, I went for the operation March 12, 1984, just about 3 months after I got there. From that day to this day, I have no feeling on my right side; I'm partially paralyzed; I can't walk unless somebody helps me. That was the one.

Again, the second time—he retired in October 1985, Dr. Alback. When he retired, he asked me, he said, "Reino, you've got to get another operation." When that man put his hand out to shake my

hand, I never saw anybody shake like that, and this is the guy that operated on me. OK, he was a retired neurosurgeon, you know, and he was more or less doing them a favor or just making some extra money, or what. He was there for 4 or 5 years and then quit after my operation. He said, "I'd never work up there again," meaning the operation room that they had in Springfield, which I believe the Director himself told you they don't operate up there any more.

But, anyway, I just wouldn't take another operation. I was afraid to. I'm crippled now. What are they going to do if they operate again?

But, what happened was a Dr. Puzzo, neurologist, out of school, he came down. He gave me all kinds of tests and everything else. He said, "Reino, I'm going to send you down for a MRI," which is a magnetic scan. It's like the cat scan, but I guess they can pick out different parts of your body and bring them forward.

Well, he sent me downtown. When he got the results, it showed a damaged nerve. He explained that the nerve that's damaged is in the center of the spine. There's nothing that could be done about it. "It's a good thing you turned down the operation."

But, in the meantime, like I am, but I was doing real good, getting up behind a chair, going to physical therapy—the finest people I've ever known down there. They're not all bad over there, Mr. Chairman. There are very, very, very excellent people. In fact, some of these boys I believe had the same people that I had in physical therapy: Mr. Hunt, Mr. Diullo. They run that place with care. They make sure you get everything you're supposed to get, and they believe in it. They help you. They're better than psychology talking to you, better than the psychologist they've got over there. They make you believe in yourself and do something. But, that's only physical therapy. The rest of the place I don't know.

But, anyway, in 1987, I believe it was—1988, 1987 or 1988—I started complaining again about my chest. I says, "Doctor, something's wrong." That was Dr. Nelson. He's the chief of medicine, not a medical doctor.

But, anyway, he had my case. He was taking care of me since Dr. Alback retired. For 2 months I kept complaining. Finally, he said, "Well, we're going to take an x ray." He said, "I'll let you know what's going on."

He took the x ray. He came back the next morning to see me. He said, "Did you get the x ray?"

I said, "Yup." I said, "You didn't see it?"

He said, "No, not yet. They'll send it to my office." He said, "We've got the lung doctor coming in next Monday." He said, "I'll have him look and we'll see what's going on."

Well, the lung doctor didn't come in next Monday. He come in the following Monday. It was 2½ weeks from the time I took that x ray. He's supposed to be a doctor. He can't read an x ray. He didn't know what was going on.

When that lung doctor seen it, he turned around and said, "What the hell are you doing with this man? He's got a bad infection." That was it. He stopped talking because he figured he can't say that in front of me. You know, I'm an inmate.

Well, they took me out of the room and brought me downstairs. About an hour later, Dr. Nelson come back down. By the way, this

lung doctor is a specialist out of, I think it was, St. Johns Hospital down there—wonderful.

He says, "Well," he says, "I took a couple of tests on you." He says, "I've got to take some more." They haven't touched me in 4 months. They didn't put a stethoscope to my chest. "What test did you take?"

He says, "Well, I've got to take some more."

A few days later all I know is I'm being taken to some place; somebody's got me on a stretcher taking me away. I went from a fat 215 pounds I am now down to 132, dying. My wife gets a telegram that I'm on the critical list. That was the third time.

Mr. HUGHES. You were at St. Johns?

Mr. REINO. Excuse me, sir?

Mr. HUGHES. You were at St. Johns Hospital?

Mr. REINO. No, I was right there—

Mr. HUGHES. In Springfield?

Mr. REINO [continuing]. At the center. Yes.

And, next I woke up there's a priest over me giving me the sign of the cross. I said, "No, I ain't dying." And I didn't.

I got everything back to where I am. But, because that man couldn't read an x ray is why I went completely backwards.

My condition—they can't fix the nerve. As I go along, I have to get worse. I don't get better. How long it is before I completely get in this wheelchair depends on me. I have to keep working. I have to keep trying and don't just sit down and let it go; I can't do that.

These are three different times. Since I had that TB—tuberculosis is what I caught and was dying. There was 15 of them that I know of on that floor that got it, including five staff members. Well, they got all the staff members right away, checked everybody out. Why didn't they check me out? I lived with the first guy that got it for 2 months. They didn't check me out.

This is the stuff that's being brought—this is what they call management over there. They don't give a damn. You might have some real good doctors there—maybe—but I haven't met any. As far as the rest of the people that manage the place, the nurses are fine, but they can't do nothing. They can do what the doctor tells them. The only thing a nurse can do is give you an aspirin if the doctor ain't there. Then you'll wait 4 hours more to get another one, and she has to mark it down. That nurse cannot give you nothing unless it's done by a doctor.

This Dr. Nelson, he's all right. He's a fine gentleman, but we call him "Dr. Quick" because he's walking saying "How you doing?" And before you get a chance to talk to him, he's gone. You know, we're felons. We're whatever you want to call it, but there's no need to treat us like that.

They need a chance. Like you asked them before, if you work together with the Bureau of Prisons and this other gentleman that was there, maybe you could do something that we needed yesterday, not next year or the year after. It's got to be done now.

I saw so many people die up there I'm scared to death. You wouldn't believe the people that die there. They're just left there, laying there and die. Don't feed them; don't give them nothing. For God's sake, have some kind of pity, some kind of mercy. Give them

a shot and kill them. Why are you letting the guy lay in bed week-in and week-out and dying? For what?

I could understand them having the AIDS patients there and don't send them home. They said they've been sending people home, you know, quicker release. But they damned sure didn't do that to anybody while I was there, not that I know of, and I can tell you, if I want to go back 7½ years that I'm in a hospital, not in jail but in a hospital, if you don't think that's not doing time, it is, rough time.

I don't know, maybe 300, 400, or 500 I saw die. I don't know. Something has to be done for these people. To me, they can't do nothing. I'm going home in 2 days. I'm done. I've got my 9 years in; it's fine, finished. Don't worry about me any more, but maybe you could do something for the other kids that are there.

Mr. HUGHES. What is it in particular that leads you to believe that the Bureau could have prevented some of the deaths? People go to the hospital all the time when they are critically ill. Unfortunately, it's a part of life; some of them die. They're not able to treat everybody and cure them of their illnesses. I suspect that many of the illnesses that you described, where the inmates died, predated their incarceration. What is it in particular that leads you to believe that the staff at Springfield did not do their very best to try to save those lives?

Mr. REINO. An Indian came on my floor. He come in from another institution, three or four rooms away from me. I very seldom leave my room because I don't want to get any more diseases; I'm too short; I want to go home. But, this Indian walked up and down the hall. And I do some painting, and he stopped by my room, and we got friendly. I says, "What are you here for?"

He said, "Ah, they're going to send me downtown for an angiogram. They've got to check my heart. They flew me in right away."

Seven weeks later he says, "When do you see a doctor around here?"

From your question, you think it's a—it's true, they don't get to you. You just lay there and wait until they've got the time to come to you. If you buy a bag of potatoes, you've got rotten potatoes in there all the time. We both know that. Half of the—maybe more than half of the claims that they got suing the Government are wrong, but the ones that are right, we don't deserve that. You've got to do something about it.

Mr. HUGHES. Let me ask you this: you had one operation in the early part of 1984?

Mr. REINO. Yes, March 12, 1984.

Mr. HUGHES. That was performed by Dr. Altman? Is that—

Mr. REINO. Alback.

Mr. HUGHES. Alback?

Mr. REINO. Dr. Alback.

Mr. HUGHES. How does he spell his name? Alback?

Mr. REINO. A-L-B-A-K or A-L-B-A-K-E, A-L-B—

Mr. HUGHES. A-C-K, or something like that? Alback?

Mr. REINO. Yes.

Mr. HUGHES. Now he performed the only operation that was performed at Springfield?

Mr. REINO. Oh, not the only one. They were doing all kinds of operations.

Mr. HUGHES. When did you have your second operation then?

Mr. REINO. I did not take the second operation. I refused it.

Mr. HUGHES. Yes. That was my question. I take it from your testimony that you had only one operation at Springfield?

Mr. REINO. That's right. And that one time—after that—

Mr. HUGHES. And what was done to attempt to correct the fracture in your neck?

Mr. REINO. Well, they took a piece of bone out of my hip and had to fuse it.

Mr. HUGHES. Who did that?

Mr. REINO. Dr. Alback.

Mr. HUGHES. Dr. Alback?

Mr. REINO. Yes.

Mr. HUGHES. That was the first operation?

Mr. REINO. Right.

Mr. HUGHES. OK. Did you ever receive any medical attention outside at St. Johns or any other facility?

Mr. REINO. No, the only time I went outside after the operation was for the MRI, which is the magnetic scan.

Mr. HUGHES. That was the only test that was performed, the MRI?

Mr. REINO. Yes, but in 1982, or the beginning of 1983, I'm not sure just when. When I was sentenced, the judge sentenced me to go through Springfield before I went to Leavenworth. He wanted a health report on me because I had had a heart attack in 1972, and he wanted them to check it out.

When I came through Springfield—I think I left there somewhere around June 1983. I went to Leavenworth, got my angiogram from them and went back, and with a clean bill of health they said; no bypasses; everything is fine. My heart's fine; just take it easy. You know, everything was fine.

Mr. HUGHES. You're in a wheelchair today. Are you able to walk on your own?

Mr. REINO. Not without help, no.

Mr. HUGHES. Not without help. And how long have you needed assistance to walk?

Mr. REINO. Seven and a half years, since they operated.

Mr. HUGHES. Since the operation?

Mr. REINO. Yes. Well, I was worse than this. I was doing real good. Like I say, if they caught the TB—I went backwards 7 years. I'm starting all over again, but the way I understand it, it'll never get much better.

Mr. HUGHES. I see. Well, thank you very much, Mr. Reino.

The gentleman from North Carolina.

Mr. COBLE. Thank you, Mr. Chairman.

Gentlemen, it's good to have you all here. I'll question you in the order of appearance.

Mr. Mayley, you indicated that you should have gone every 3 months but you didn't go. Refresh my memory. I didn't read that clearly.

Mr. MAYLEY. Dr. Jackson from the Mayo Clinic wanted to see me every 3 months, and there's much documentation about this, to

check my neck and facial area for tumors, cancerous lumps. They were very concerned about the cancer reoccurring after the treatment at Springfield.

Mr. COBLE. But, you did not go back, you did not return every 3 months?

Mr. MAYLEY. For, I believe it was, about 6 months, two trips, I went back and saw him, and we discussed a reconstruction package. As we would do that, he would feel all around the areas that they were concerned with the cancer reoccurring. Then after the cancer came back, I never saw Dr. Jackson again. After the lump reappeared, I never saw him until they operated on me.

Mr. COBLE. I guess you felt that you should have seen him periodically, did you not?

Mr. MAYLEY. I didn't understand.

Mr. COBLE. Was it your belief that you should have been in contact with him, or he in contact with you, on a periodic basis?

Mr. MAYLEY. It was my belief from the staff at the Federal medical center that I was waiting to see him.

Mr. COBLE. OK.

Mr. MAYLEY. They were telling me, "You're going to go see this man. Don't worry about it. You're going to see Dr. Jackson."

Mr. COBLE. I presume that there is an administrative remedy process available. Did you ever think to go to somebody and say, "Listen, I saw my doctor several weeks ago. I think the time has come to see him again?" Did you ever initiate that sort of thing, Mr. Mayley?

Mr. MAYLEY. We initiated many avenues as far as writing to the U.S. Congress, the U.S. Senate. Of course, we get this stereotype answer because the letter was returned back to the warden, and the warden would say you're free of cancer and nothing happened. The same letters—the letters are the same for every letter.

I did file from Terre Haute—when they transferred me, after they cleared me medically, they transferred me to Terre Haute. I spent about 3 weeks at Terre Haute. I filed administrative remedies in Terre Haute which were never answered because it was sent back. I sent it directly to the region, and it was returned to me. They told me that my administrative remedy didn't show merit and that I was going to ship back to El Reno from Terre Haute. We filed litigation to come back.

Mr. COBLE. And, I assume, Mr. Mayley, that the physicians with whom you were in contact were not outside physicians? They were physicians assigned to the institutions?

Mr. MAYLEY. Yes, sir.

Mr. COBLE. Public Health Service physicians?

Mr. MAYLEY. No. Two of these physicians were retired, and they worked at the Federal medical center.

Mr. COBLE. OK. Thank you, Mr. Mayley.

Mr. Blitzstein—

Mr. BLITZSTEIN. Yes, sir.

Mr. COBLE [continuing]. I don't mean this to sound humorous in any way, but in fact it's sad humor when I say that, other than the fact that one guy said, "Cut your leg off," and other than the fact that somebody pulled you off of your heart medicine that may have

accelerated other trouble, you were OK? As I say, that's sort of a sad humorous approach, but—

Mr. BLITZSTEIN. I'm OK, yes.

Mr. COBLE. This is frightening, Mr. Chairman, to me, if in fact some physician did say, "Whack his leg off," as you described—

Mr. BLITZSTEIN. I have a court reported documented—

Mr. COBLE. Now was this a Public Health Service physician?

Mr. BLITZSTEIN. No, sir.

Mr. COBLE. Outside physician under contract?

Mr. BLITZSTEIN. No, no, a physician from Terminal Island. I don't know who he was.

Mr. COBLE. OK.

Mr. BLITZSTEIN. I don't have the record of him right now, but I could—

Mr. COBLE. It appears, Mr. Blitzstein, that you give a mixed review. On the front end—that is, in the California end—not too favorable—

Mr. BLITZSTEIN. Right.

Mr. COBLE. But, as you came back East, you have apparently sterling and favorable comments to make?

Mr. BLITZSTEIN. Well, they saved my life; there's no question about it.

Mr. COBLE. Yes.

Mr. BLITZSTEIN. Yes. I just think that where there's smoke, there's fire. When you see writs filed against all these PA's, or whoever it might be, and legal action taken against these people, I think somebody from the outside should look in and see what it's about—people other than the Government staff. People just don't file lawsuits against people for no reason. When you get a person who has multiple suits against them and whatever, there's a reason for it. I know we're inmates and maybe we're noted as second-class citizens; I don't know, but not everybody's the same.

Mr. COBLE. Well, the chairman and I, you may recall, Mr. Blitzstein, earlier today in our exchange with the Director, we indicated the importance of outside review.

Mr. BLITZSTEIN. Right.

Mr. COBLE. Sir, your name is pronounced—

Mr. REINO. Reino.

Mr. COBLE [continuing]. Reino. Mr. Reino. Thank you, Mr. Blitzstein.

Mr. BLITZSTEIN. Yes.

Mr. COBLE. Mr. Reino, at one point in your testimony you said, "That's where they saved my life." Where was that?

Mr. REINO. The University of Kansas City Hospital, sir.

Mr. COBLE. And you were in custody at what institution at that time?

Mr. REINO. Leavenworth.

Mr. COBLE. OK. So, you were dispatched from Leavenworth to Kansas City.

Mr. REINO. Yes.

Mr. COBLE. And this medical attention was delivered by, I presume, civilian physicians—

Mr. REINO. Yes, sir, in the hospital.

Mr. COBLE [continuing]. Civilian medical staff not connected with the Bureau of Prisons?

Mr. REINO. No, sir.

Mr. COBLE. OK. Mr. Chairman, I believe that's all my questions. Thank you, gentlemen, for appearing before us.

Mr. HUGHES. The gentleman from Illinois.

Mr. SANGMEISTER. I was not here for the very beginning of your testimony, but there's something that I wanted to get straight. Mr. Mayley I know has a lawsuit pending. Mr. Blitzstein, you made reference to lawyers and depositions. Do you have a lawsuit pending?

Mr. BLITZSTEIN. We haven't filed it yet, as of this time.

Mr. SANGMEISTER. OK, but it's being contemplated. And, Mr. Reino, where are you as far as litigation is concerned?

Mr. REINO. I have a suit.

Mr. SANGMEISTER. You have a suit pending?

Mr. REINO. Yes, I do.

Mr. SANGMEISTER. So, all three of you, then, are involved in it. Taking at first blush that everything you said is true that's happened to you, and I don't deny that it has, apparently there is malpractice involved in all three of your cases. Of course, that happens out in the regular life as well.

But, the thing that I'm interested in trying to get at, and I think the chairman's trying to get at, too, if you can put your own strong feelings in this area aside, how does the general population that you live with every day feel? Do you hear a lot of complaints about health problems?

Mr. REINO. Yes, we do. Yes.

Mr. SANGMEISTER. Anyone that wants to answer that?

Mr. MAYLEY. People are scared to death. It comes down—if you're in a Federal medical center and you have Dr. Canatella as your doctor, you don't have anything to worry about. You have a woman that cares about your life. She should be the medical director of that place, running that place, because she cares.

If you have Dr. Tron, you might have to speak three different languages to understand what this guy says. He doesn't even speak good English. If you try to explain something to him, he doesn't listen. "I don't understand" or—

Mr. SANGMEISTER. Well, I have a few doctors in my local clinic that are that way, too. I understand.

[Laughter.]

Mr. MAYLEY. But, my doctor, Dr. Kemp—

Mr. SANGMEISTER. That's aggravating. I understand.

Mr. MAYLEY [continuing]. I'm scared to death of the woman. I mean, I just spent the last 7 months getting someone there to listen to me enough to send me downtown to have a bone spur removed off my hip. It's doing damage internally. It's taken me 7 months playing games with—I go from this doctor, "Well, I'm going to send you to this doctor over here and let him look at it." It's plainly visible on the x rays. The x-ray reports come back showing it, that I have these problems.

Mr. SANGMEISTER. So, is there an attitude there in the population, then, that unless you've got something really seriously wrong, that you're better off not to even ask for any medical help? Is that the kind of atmosphere that you're talking about?

Mr. MAYLEY. There's a lot of people that won't go near them until something really serious happens. But, like someone in my case, I'm scared; I don't want to die. I do everything I can, working out, healthwise, trying to survive. I went down to 150 pounds during this operation, and it's taken me 4 years to get some of the use back that I've lost and to get my health back. I'm afraid; I want to be healthy. When I have a problem, I don't go to them, as they say, to manipulate or to want to stay in Rochester. I go to them because I know something is wrong with my body.

All they did for this 7-month period of time, Dr. Thompson and Dr. Kemp, is just say, "It's your weight training. If you would stop lifting weights, you wouldn't have this problem."

Then I finally see an orthopedic specialist who says, "We have to remove this bone spur. It's not your weight training. That's where they took the bone out to put in your jaw."

Mr. SANGMEISTER. Mr. Blitzstein, do you generally feel the same way? If I asked you the question: If you were in charge, what would be the one thing that you'd like to see done as far as medical services are concerned?

Mr. BLITZSTEIN. I really don't have that much of a complaint against the medical services at Rochester. I mean, I had Dr. Canatella and I've had the occasion to use Dr. Thompson. As far as I'm concerned, they're the two best doctors. So, I don't really have a complaint against them. But, what I hear is that there are people that have a lot of complaints, you know, but I personally don't. I have great therapy, and she is a very caring person. She's my doctor and she calls me down whenever she wants to see me. She's on top of things very, very much.

Mr. SANGMEISTER. What about you, Mr. Reino?

Mr. BLITZSTEIN. And the nurses are terrific there. I mean, really I mean I have good medical care at this time, you know.

Mr. SANGMEISTER. Mr. Reino.

Mr. REINO. All I got to say is they claimed before, one of them said that they don't retaliate, they don't do this, they don't do that. Look up the records for the past month. They shipped out over 100 people, 100 guys, from Springfield, running them all around the country. They tried to do it to me last week. A week ago Thursday they tried to ship me out. I said, "You can't ship me. I'm being subpoenaed to New York. Where are you shipping me?"

He says, "You're going."

I said, "OK." I started to the phone, picked up the phone and he said, "Wait a minute. Let me check you out first. Let me make sure."

They would have had me to go on a bus to El Reno, an 8-hour ride by bus.

Mr. SANGMEISTER. And you believe—

Mr. REINO. Tell me they are not retaliating against people?

Mr. SANGMEISTER. If I understand you correctly, the reason that they're just moving you around is because you're—

Mr. REINO. They're moving them around for the simple reason—you check on how many of them guys sent letters to people like you.

Mr. SANGMEISTER. And you think there's—

Mr. REINO. Just check on the last 100 guys that were shipped out of Springfield and find out how many letters were sent to you people, and you'll find out if they're harassing these people or what.

Mr. SANGMEISTER. So, if you write your Congressman, you're going to get shipped; is that what you're saying?

Mr. REINO. Oh, yes, they shake you down and steal all your paper and say, "Yes, we shook him down, but we didn't see no papers in there. Go ahead and prove it now."

Mr. SANGMEISTER. That's all I have.

Mr. HUGHES. I just have a couple of questions. Now I'm confused, Mr. Blitzstein. You indicated that you have no complaints, and yet I understood you to—

Mr. BLITZSTEIN. I have no complaints against FMC, Rochester.

Mr. HUGHES. Oh, Rochester?

Mr. BLITZSTEIN. Yes, sir.

Mr. HUGHES. Because I understood that—

Mr. BLITZSTEIN. Or Valley Hospital.

Mr. HUGHES. I understand you do have some complaints against some within the system?

Mr. BLITZSTEIN. Well, at Boron, CA.

Mr. HUGHES. Boron, CA.

Mr. BLITZSTEIN. And the doctor that came to Valley Hospital in Las Vegas.

Mr. HUGHES. I see.

Mr. BLITZSTEIN. Those are my complaints. I don't have any other complaints.

Mr. HUGHES. I see. Well, let me see if I can summarize, as best I can, what I take to be your testimony. I gather there are good parts to the system and some parts that need some attention.

Mr. BLITZSTEIN. Yes, there are caring people and there are not caring.

Mr. HUGHES. There are people that care and there are people that you have the impression do not care?

Mr. BLITZSTEIN. Right.

Mr. HUGHES. You have some competent people in staff and medical positions, and you have some that are not so competent?

Mr. BLITZSTEIN. Yes.

Mr. HUGHES. Unfortunately, there are language problems as my colleague from Illinois stated, around the country in the private sector as well as in the institutions.

Mr. BLITZSTEIN. Yes.

Mr. HUGHES. There are not enough physicians. I think the Director in his testimony alluded to the fact that we have 25 vacancies out of 175.

Mr. BLITZSTEIN. Yes. There are also other problems, Congressman. I mean, I hear doctors take away a diabetic's snacks at night or bananas or fruit, whatever, because it's too expensive now and the budget can't call for it. You can't have this cream for your leg. It's the money factors now. I just say, if I needed a pill to keep me alive, if it was too expensive, maybe I wouldn't get it; I don't know.

Mr. HUGHES. Did you or your colleagues experience any situations where certain drugs were unavailable and they changed your prescription because they had other drugs in inventory that were available?

Mr. BLITZSTEIN. I don't have that problem.

Mr. HUGHES. Does anybody have that problem?

Mr. MAYLEY. I just had that problem in the last few days. I was——

Mr. HUGHES. In transit you had that problem; do you mean?

Mr. MAYLEY. No, no. They flew us up today. Three days ago I was ordering my own stuff—I have permanent implants—to clean my teeth, and that was a problem of, "Well, you can't do that." It was approved by the acting medical director, and the guy, the head of education says, "You can't buy this stuff."

I say OK. So I go back to the doctors, and they decide now they're going to supply me with this stuff which was easier for me to buy. In the meantime, I asked for some sun screen because I have sensitive skin to the sun and I ran out of sun screen. Now it's, "Oh, you can't have this. You have to go buy this."

There's discrepancies about that. It's——

Mr. COBLE. It's a money problem.

Mr. MAYLEY. They complain about, well, gee, we're worried about giving you a \$2 bottle of sun screen, or something along that line, and then, on the other hand, they'll spend 3 or 4 days reviewing how much money you have in your commissary account to determine if you can buy it.

I wish I knew the figure of money that has been spent on me since January 1987. I know what it would cost to remove a small lump from my neck if they would have done it when I first asked them to do it. We used to pay the plastic surgeon \$2,500 or \$3,500. There's not an operation I've had in the last 4 years that comes close to that figure.

Mr. HUGHES. How many operations have you had in the last 4 years?

Mr. MAYLEY. At least six.

Mr. HUGHES. Six operations?

Mr. MAYLEY. Between——

Mr. HUGHES. The same condition each time?

Mr. MAYLEY. The same condition, reconstruction, and——

Mr. HUGHES. Reconstruction?

Mr. MAYLEY [continuing]. Trying to make it to where I can eat again.

Mr. HUGHES. How many were reconstruction as opposed to surgery to deal with——

Mr. MAYLEY. Since the major, it's been all reconstruction, since January 23, 1987.

Mr. HUGHES. It's all been reconstruction?

Mr. MAYLEY. It's all been reconstruction or repairing reconstruction which I'm going for now again.

Mr. HUGHES. There are two things that you alluded to, Mr. Reino, that I want to ask you a little more about. You indicated that you were privy to a partial conversation between a doctor from St. Johns Hospital?

Mr. REINO. Yes?

Mr. HUGHES. In which he looked at the x ray and said that, "This man needs attention right away. What are you doing?"

Mr. REINO. This was the lung specialist from St. Johns when he came into the institution.

Mr. HUGHES. Into the institution?

Mr. REINO. Right.

Mr. HUGHES. At Springfield?

Mr. REINO. Maybe once or twice every 6 months or so, 3 months or so.

Mr. HUGHES. Were you present when that conversation took place?

Mr. REINO. Yes, I was.

Mr. HUGHES. And, was it—describe the conversation again to us.

Mr. REINO. Well, when I went into the room, he says, 'Hi there, Reino. How are you doing?'

"I don't know, Doc. My chest is bothering me. I don't feel good."

He says, "You don't look too good." He turned around and said to Dr. Nelson, "Do you have an x ray taken?"

He said yes. He walked out and gave him the x ray. He put it up on the window and he said, "My God," he said, "what are you doing about this? This man's got a bad infection." Well, I had TB is what I had.

Now here's a doctor holding it for 3 weeks, and he can't read it?

Mr. HUGHES. Now were there other conversations where you were present between outside physicians and medical personnel?

Mr. REINO. No. No, that—

Mr. HUGHES. Who was the physician present during that conversation with the expert from St. Johns?

Mr. REINO. Dr. Nelson—

Mr. HUGHES. Dr. Nelson.

Mr. REINO [continuing]. Was the one he was talking to.

Mr. HUGHES. What was his position at the medical facility at Springfield?

Mr. REINO. Well, he's up on the board as chief of medicine.

Mr. HUGHES. He's chief of medicine?

Mr. REINO. Yes, sir.

Mr. HUGHES. Was that the only time that an outside consultant had a conversation with Dr. Nelson or any other medical providers at Springfield, to your knowledge?

Mr. REINO. Well, whoever comes into Springfield comes in under your doctor, whether it's Lieberwitz or Nelson or anybody else that they have there.

Mr. HUGHES. But, my question is, were you present when any other outside physicians came in and talked with your—

Mr. REINO. And had conversations? No, sir.

Mr. HUGHES. That was the only time?

Mr. REINO. The time I was present when an outside one was the lung—

Mr. HUGHES. Now let me ask you about harassment, and you or anyone else at the table can answer. Is the transportation of prisoners, particularly by bus, viewed upon as a form of retaliation? Is that what I gather from your testimony?

Mr. REINO. Do I look like somebody you can put on a bus for 8 hours with no air, no electrical impulse used to kill the pain? That's what it is. It's an 8-hour ride from Springfield to El Reno, OK.

Mr. HUGHES. And that was a trip that you were to have made, but which you did not make?

Mr. REINO. No, I didn't make it. I told them I was going to call here. "I'm going to call Washington. They've got me subpoenaed."

Mr. HUGHES. What was the explanation as to why you were going to El Reno?

Mr. REINO. Why I was going to El Reno?

Mr. HUGHES. Yes.

Mr. REINO. They just don't like the idea of people coming to you or writing to you people or talking to you people.

Mr. HUGHES. Was that as a result of your appearing here today? Is that what you're suggesting?

Mr. REINO. Yes, I am.

Mr. HUGHES. Did you actually see a formal order executed or were you just informed that you were going to El Reno?

Mr. REINO. They come and packed my stuff to take it all out. Then when I said, "OK, I'm going to call Washington." I said, "I'll call my son and find out." But, I didn't call right away. It wasn't 5 minutes and they said, "No, you're not going. It's a mistake."

Mr. HUGHES. Well, I have no further questions. Does the gentleman from North Carolina have any?

Mr. COBLE. No, Mr. Chairman.

Mr. HUGHES. Well, thank you very much for your willingness to come to testify. You've been very helpful to us. Mr. Reino, we wish you well on your discharge from the system on Friday. Mr. Blitzstein and Mr. Mayley, we thank you for your testimony today, your contributions. I have no doubt but that you've helped us better understand perhaps the good points as well as some of the problems. I think that was the thrust of your testimony: there are good aspects to the system and there are some areas that need some attention. We appreciate that. Thank you very much.

I'm going at this point, before we take the third panel, to recess for lunch. I realize that some of you have other pressing business this afternoon, but we're going to recess until 2:30 p.m. Thank you.

[Whereupon, at 1:30 p.m., the subcommittee recessed, to reconvene at 2:30 p.m., the same day.]

AFTERNOON SESSION

Mr. HUGHES. The subcommittee will come to order.

I'd like to welcome our third panel this morning: Ms. Elizabeth Alexander, Dr. Kim Thorburn, Dr. Robert Greifinger, and Dr. Dante Landucci.

Ms. Alexander is the associate director of litigation for the National Prison Project of the American Civil Liberties Union's National Prison Project. She's litigated prison health care issues in a number of States around the country and recently examined conditions at the Springfield medical center.

Dr. Thorburn is an expert in correctional health care and serves as the medical director for the Hawaii Department of Public Safety.

Dr. Greifinger is a medical director of the New York State Department of Corrections and brings his experience in medical administration to the field of correctional health.

Dr. Dante Landucci is our final witness today. Dr. Landucci is a former chief health programmer for the Bureau of Prisons Detention Center in Los Angeles and also worked for a number of years at the Federal prison hospital in Springfield, MO. His testimony

this morning will be in response to questions. He's not been cleared to offer a statement. So, I will question him on those aspects of his testimony, or he may proceed as he sees fit.

We welcome you here. We have your statements, those of you who have submitted statements. Without objection, they'll be made a part of the record. Why don't we begin with you, Ms. Alexander? Welcome.

STATEMENT OF ELIZABETH ALEXANDER, ASSOCIATE DIRECTOR OF LITIGATION, NATIONAL PRISON PROJECT, THE AMERICAN CIVIL LIBERTIES UNION

Ms. ALEXANDER. I want to thank you for this opportunity. I'm extraordinarily pleased that the committee would take time from its busy schedule to address this issue.

In my written testimony I have attempted to demonstrate the existence of serious medical problems in the Bureau. I disagree with the characterization of these problems as reflecting simply isolated examples.

Take the *Isabel Suarez* case from my written testimony. This involved a situation in which a pretrial detainee, someone not convicted of a crime, was deprived of her medicine for epilepsy. The prisoner repeatedly asked for help and wasn't seen by a doctor for a considerable period of time, until this woman went into a coma, and 2 weeks later she was dead. All the time that she was deprived of her medication she was asking for help. Other prisoners were asking that she be helped.

What this case reflects is not an isolated tragic example. What this reflects is a system that didn't work, because time went on. It wasn't simply that she was deprived of the medication, but that nothing worked to get that medication back until that woman was in a coma.

Numerous other examples also show a system that doesn't work. And, similarly, I think the important point to recall from the testimony from the three prisoners here today is that it demonstrates what happens when a system doesn't have quality control that works. Many of the health care providers in the Bureau are dedicated and caring; there's no question about that. No one would challenge that.

But, if a prisoner is unfortunate enough not to get one of those providers, the prisoner is not in a position to do anything about it, and the system doesn't address it. So, the cancer recurrence of Mr. Mayley goes unaddressed for a long period, or the doctor with shaking hands performs surgery that results in the partial paralysis of the prisoner, or the misread x rays aren't seen and the TB diagnosed for a period of time.

Mr. Chairman, if you or I happen not to trust the doctor that we go to in the community, we have a choice. We can determine that our health care needs aren't being served and we have other options to address those health care needs. The problem for prisoners, unfortunately, is that they have no choice. Because they have no choice, it is critically important that the systems be in place and that the systems address the need for quality health care for everyone. If there's one thing I would hope that the chairman would carry away from this hearing, it is the importance of systems so

that these cases that have been documented don't continue to happen in the Bureau.

I would like to address briefly some of the comments in Director Quinlan's written testimony. I want to start with something that also came up in the Director's oral testimony. In the written testimony, Director Quinlan refers to a 10-percent vacancy rate in health care personnel throughout the system. The vacancy rate for physicians, however, is far higher. Thirty out of 153, or about 20 percent, of the physician positions are currently unfilled. I note that these are not the same figures that the committee was given this morning. I have here at the table with me in writing, dated July 16, 1991, from the Bureau of Prisons, the information that there are 153 physician positions and 30 of those are vacant. I would request permission to give this to the committee following the hearing.

Mr. HUGHES. Without objection, it will be received into the record.

[The information follows:]



U.S. Department of Justice

Federal Bureau of Prisons

July 16, 1991

Washington, DC 20534

Elizabeth R. Alexander
Associate Director for Litigation
American Civil Liberties Union Foundation
1875 Connecticut Avenue, N.
Washington, D.C. 20009

Dear Ms. Alexander:

This is in response to Mr. David C. Fathi's letter of July 8 in which he requested information regarding medical care in the Bureau of Prisons. The answers that follow correspond to the order in which Mr. Fathi raised his questions in his letter.

1. 153 positions - 30 vacant
2. Not all of our facilities have a full-time physician. Eight of the Federal Prison Camps provide services via a contract physician and the Federal Medical Center in Carville, Louisiana contracts for all health care with the Public Health Service's Hansen Disease Center which is located adjacent to the Federal Medical Center.
3. Yes.
4. The USMCFP, Springfield has: 20 physician positions
78 RN positions
43 LPN positions
5. Springfield's patient count is 598 (352 are medical/surgical patients and 246 are mental health patients).
6.

	<u>Inmate</u>	<u>Staff</u>
May '88	44,097	13,205
May '89	49,568	14,944
May '90	58,170	17,560
May '91	64,200	19,779

I trust that the above is responsive to Mr. Fathi's request. Please feel free to contact me if you have any questions.

Sincerely,

Wallace H. Cheney
Wallace H. Cheney
Assistant Director/General Counsel

AMERICAN CIVIL LIBERTIES UNION FOUNDATION

THE NATIONAL PRISON PROJECT

July 8, 1991

BY FACSIMILE

Ms. Nancy Redding
Office of the General Counsel
Federal Bureau of Prisons
320 First St. N.W., Room 754
Washington, DC 20534

Dear Ms. Redding:

As we discussed by telephone today, I am making this written request for certain information regarding medical care in the Bureau of Prisons. I initially asked for most of this information in a telephone conversation with you, but you asked that I put my request in writing.

I would appreciate it if you could provide me with the following information at your earliest convenience:

1. How many staff physician positions does the Bureau currently have, and of these, how many are currently vacant?
2. Do all of the Bureau's 55 prisons currently have a full-time physician?
3. Is there currently a full-time gynecologist on staff at Lexington?
4. How many positions does the Springfield Medical Center currently have for (1) physicians, (2) registered nurses, and (3) licensed practical nurses?
5. How many patients are currently confined at Springfield?
6. I would also appreciate any information you have on the increase in the prisoner population of the Bureau in recent years, as well as increases in the number of staff.

1875 Connecticut Avenue, NW
Washington, D.C. 20009
(202) 234-4830
Fax # (202) 234-4890

Allen J. Bronstein
Executive Director

Adrian A. Anystora
Associate Director
for Administration

Elizabeth R. Alexander
Associate Director
for Litigation

Shurtliff H. Adams, Jr.
David C. Faith
Alexis P. Freeman
Edward I. Korman
Mark J. Lopez
Staff Counsel

Jan Elvin
Editorial and Journal

Betsy Bernat
Assistant to
the Director

Kelly Gardner
Public Relations

Judy Greenstein
Associate Information
Coordinator

Kenneth Blackwell
Marie Martino
Solomon N'je
Staff Associates

National Headquarters
132 West 43 Street
New York, NY 10036
(212) 944-9800

Norman Dorsen
President

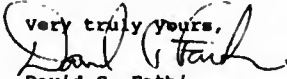
Ira Glasser
Executive Director

Eleanor Holmes Norton
Chair
National Advisory Council

We are seeking this information in connection with the upcoming hearing on medical care in the Bureau before the House Subcommittee on Intellectual Property and Judicial Administration. The hearing is scheduled for July 17; we have been invited to testify at that hearing, and must submit our testimony no later than July 15. We hope you will be able to respond to this inquiry by the end of this week, so that we may provide the Subcommittee with the most current information available. If not, we will simply inform the Subcommittee that we were unable to obtain current data from the Bureau, and will rely on the information we have.

Thank you for your kind cooperation.

Very truly yours,


David C. Fathi

Ms. ALEXANDER. Director Quinlan also indicates on page 2 of his testimony that emergency care is available around the clock in the Bureau. This is an issue of some controversy because even the Bureau's flagship institution, the Springfield medical facility, with about 600 patients, does not have 24-hour onsite physician coverage. Some of the examples of inappropriate medical care I cite in the written testimony resulted from that lack of 24-hour physician coverage at Springfield.

Similarly, on page 4 of Director Quinlan's testimony, he notes that, "Each Bureau facility operates at a minimum a primary care ambulatory clinic staffed by licensed physicians, dentists, nurses, physician assistants, and other providers." The reality is, however, that many Bureau facilities do not have a full-time physician.

As Director Quinlan noted today also, for 10 years the only physician at the U.S. penitentiary at Marion had no license to practice medicine. Although I heard Director Quinlan say that now all physicians who have direct patient contact have licenses, he certainly did not say that all physician assistants are now certified, and apparently they are not so certified.

I would also suggest that any lawyer who has had clients in the Bureau of Prisons would doubt the claim made by Director Quinlan on page 5, that "prisoners whose medical condition contraindicates extended ground transport are not so transported." Director Quinlan's statement is belied by numerous examples of seriously ill patients transported hundreds of miles by bus or van, sometimes without their medication, and frequently without even basic medical records. This has often resulted in serious harm to prisoners.

Director Quinlan referred to the Bureau's commitment to community standards in the area of AIDS treatment. I welcome that commitment, but I don't think that it is the current reality within the Bureau. In a case in the last several years, the Bureau indicated that it understood that it could not provide community-level health care at the MCC in Miami, but said community-level health care for AIDS was available at Springfield. Yet, the reality is that Springfield had a very high unexplained death rate from bronchoscopies on patients with AIDS and that there were numerous other problems with treatment of AIDS even at its flagship facility.

Many of the Bureau's statistics, not simply the statistics regarding physician vacancies, are misleading and contradictory. For example, on page 6 of Director Quinlan's testimony, he indicates that there were 19 medical administrative remedy requests filed at Springfield in 1989. However, in documents provided to the news media, the Bureau of Prisons lists 38 such complaints, or twice as many, at Springfield in 1989.

We've noticed a number of other discrepancies in the information supplied to the committee, and in all the cases of these discrepancies in the statistics the Bureau's apparent errors in those statistics underreport the rate of complaints about medical care. And, yet, even so, I'm surprised that so many prisoners are brave enough to challenge their medical care within the Bureau. There are substantial disincentives to such challenges by prisoners.

After our interviews at Springfield, a number of patients that we had interviewed found that they were suddenly scheduled for

transfer. Prisoners who file lawsuits are frequently transferred by the Bureau, and during their transfer process their legal papers somehow disappear. When their legal papers are lost, prisoners frequently miss deadlines and have their cases thrown out by the court or they just give up.

In addition, since the committee scheduled this hearing on medical care, a number of patients at Springfield who have been cooperating with us have been harassed by staff. Prisoners have had documents that they intended to send to the National Prison Project or to Members of Congress seized from their cells.

Let me make one final point. According to Director Quinlan's testimony, the Bureau paid out over \$3.6 million in judgments and settlements for bad medical care in the last 3 years. The committee may well want to ask: What, if any, disciplinary action was taken against the staff responsible?

In a recent case to which the chairman referred in his questions, the Bureau was ordered to pay \$400,000 for botched surgery. Yet, after the surgery that maimed a patient for life, the doctor responsible was promoted to chief of surgery at Springfield, where he remains as chief of surgery to this day.

And I said I had a final point, but I guess I have one more. Director Quinlan appropriately responded to questions from the committee regarding outside review by saying that he was interested in exploring the idea of outside review of the medical care, but yet he was concerned that the Bureau pick the person who would do the review. I'd like to point out that a similar recommendation that the Bureau retain an outside medical expert to review its medical care was made by a conference on medical care held within the Bureau in December 1989, and that recommendation for such a review, with the Bureau picking the person, went to Director Quinlan. The Director decided at that time not to act on that recommendation.

Thank you. I'd be happy to answer questions.

Mr. HUGHES. Thank you.

[The prepared statement of Ms. Alexander follows:]

PREPARED STATEMENT OF ELIZABETH ALEXANDER, ASSOCIATE DIRECTOR
FOR LITIGATION, NATIONAL PRISON PROJECT, AMERICAN CIVIL
LIBERTIES UNION

Summary of Testimony of the National Prison Project

The National Prison Project welcomes this Subcommittee's examination of problems in medical care within the Bureau of Prisons. As a result of medical staffing that is deficient in both numbers and qualifications, as well as medical programs that are poorly organized and below community standards, too often a sentence to the Bureau of Prisons becomes in effect a sentence of death, or at least a sentence to unnecessary suffering and permanent disability. The current overcrowding crisis within the Bureau merely exacerbates the existing crisis in the medical system.

The Bureau's medical transport system subjects severely ill patients to long and arduous bus journeys, often for weeks at a time, sometimes resulting in death or serious aggravation of existing health problems. Patients are sometimes deprived of necessary medication during transportation. Medical records often fail to accompany patients who are transferred, making it difficult to treat them when they reach their destination. Care of patients with AIDS and HIV infection is seriously deficient throughout the system. The mental health program at Springfield is virtually unstaffed, and inadequate supervision of mentally ill patients has resulted in several tragic incidents. Other persistent problems include inadequate care of diabetic and dialysis patients, and the Bureau's refusal to permit kidney transplants under any circumstances.

The Bureau needs to promulgate policy immediately that bars the use of unlicensed health care providers and the use of prisoners to provide health care-related services for their fellow prisoners. The Bureau should also retain an independent expert in correctional medicine to perform a comprehensive evaluation of its medical care system. This evaluation should address the problem of safely transporting patients, develop a plan for meaningful quality and peer review, and examine the option of reducing substantially the Bureau's reliance on in-house staff for complex medical procedures.

Testimony of the National Prison Project
of the American Civil Liberties Union
On the Problems of Health Care in the Bureau of Prisons

Introduction

Thank you for giving me the opportunity to present testimony to the Subcommittee, on behalf of the National Prison Project, on the issue of health care within the Bureau of Prisons. The Subcommittee's demonstration of concern through the scheduling of this hearing is gratifying.

My first contact with health care issues in the Bureau of Prisons came about two years ago. A friend of a federal prisoner called me out of great concern for his friend's situation. The prisoner was confined at a federal facility in the mid-Atlantic area. The prisoner had AIDS, and he was experiencing severe episodes of fever, as well as constant diarrhea. Because of the prisoner's medical condition, the Bureau had decided to transfer him to the Springfield Medical Facility in Springfield, Missouri.

I was at first puzzled by the friend's concern. So far, it appeared that the Bureau was making an appropriate decision to transfer a desperately sick prisoner to a facility where he could receive medical care. What was the problem?

The problem, the friend informed me, was that the Bureau's mode of transporting the prisoner was to place him in the custody of the U.S. Marshal's Service for transport by van or bus to Springfield. The Marshal's Service ordinarily does not transport prisoners directly, but rather goes back and forth between institutions, until the prisoner ultimately hooks up with a van or bus that happens to be headed for Springfield. Accordingly, this

prisoner was shackled to a seat for hours on a bus going north to New York, not west to Missouri. According to his friend, the prisoner was in agony on the van, did not have his medication, and was unable to get access to a toilet despite his active diarrhea. He was forced to defecate himself in his own clothing.

I agreed to try to reach someone in the Bureau of Prisons to see if I could confirm any part of the friend's story. I tried several people within the Bureau, and was referred repeatedly to someone else. Each person I spoke to, however, assured me that there was a system in place to make certain that no one was transported by van through the Marshal's Service whose health would be adversely affected by such treatment.

By the time we actually located the prisoner he was in Danbury, Connecticut and running a high fever. As far as I was later able to determine, every allegation of the friend about the prisoner's treatment was correct. Apparently, solely because an outside lawyer happened to get involved, someone in the Bureau reviewed the prisoner's health care and made the determination that he was too sick to spend weeks being transported by van. The prisoner's immediate ordeal with the Marshal's Service came to an end and the Bureau agreed to transport him by air to Springfield.

Although I have been involved in prison litigation for about twenty years, I was amazed that such an appalling example of medical abuse could occur within the Bureau of Prisons, which has traditionally enjoyed a reputation as more professional than most

state corrections systems. In discussing this issue with lawyers who deal on a regular basis with federal prisoners, however, I have discovered much evidence that the Bureau is in no sense a leader in the area of medical care. Essentially every such lawyer with whom I spoke had at least one example of a client whose health needs were ignored or badly treated by the Bureau.

Subsequently, a number of events, including the outstanding series of articles by Olive Talley in the Dallas Morning News documenting numerous problems with health care within the Bureau, caused the National Prison Project to open a formal investigation into health care, an investigation that is now focused on the Springfield Medical Facility.

The relentless tide of overcrowding within the Bureau has exacerbated existing problems in health care, as it has in so many other areas. Between 1983 and 1988 the census of the Bureau grew by 75%, but staff levels increased by only 23%.¹ Unfortunately, when adequate health care is denied, a sentence to the Bureau of Prisons can become a sentence of death, or at least a sentence to unnecessary pain and the loss of health.

Staffing Levels

In December of 1990, a reported 40% of the physician positions, including three of the six psychiatrist positions, were unfilled at the Springfield Medical Facility. This represented the

¹ Dallas Morning News (DMN), 6/25/89.

worst shortage in the last five years.² As of June 1991 an astounding six of seven psychiatrist positions were vacant at Springfield.³

While the shortages at Springfield, traditionally viewed as the Bureau's flagship medical institution, are by themselves critical, the same level of shortage has persisted throughout the Bureau. As of June, 1989, the Bureau had 39 vacancies among its medical/surgical staff of 129 doctors.⁴ Not all of the 55 Bureau prisons even have a full-time doctor.⁵

But even if the Bureau's health care staff had no vacancies, the staff/patient ratios bear no resemblance to the levels that exist in comparable private facilities. For example, the Springfield Medical Facility has thirteen doctors and 113 nurses (most of the nurses are licensed practical nurses, not registered nurses) to provide services for 604 medical/surgical patients and mental patients. In sharp contrast are the staffing patterns of two other hospitals in the Springfield, Missouri area. St. John's Hospital has 557 patients and Cox Hospital, 483. Each of these

² Springfield, Missouri News-Leader (SNL), 12/23/90.

³ Washington Post (WP), 6/14/91. Ironically, seven positions for psychiatrists may represent a reduction in the number of authorized positions at Springfield. A fact sheet distributed by the Bureau of Prisons in December, 1989 referred to eight psychiatrist positions.

⁴ DMN 6/25/89.

⁵ DMN 6/25/89.

private hospitals has approximately 450 admitting physicians and up to 1100 nurses.⁶ Even if some of this gross disparity is explained by the differing staff organizations and possible differences in the mission of the facilities, it is apparent that the levels of staffing at the Springfield Medical Facility simply do not reflect community standards. One result is that there is routinely no physician at Springfield after 4:00 p.m. on weekends. No similarly sized private hospital could be so operated.⁷

The shortage in physicians leads to other medical staff attempting to perform functions for which they are not trained. Dr. Dante Landucci, formerly a staff physician at Springfield, wrote the following to Springfield Warden Turner on December 22, 1988:

[Physician's assistants] and nurses are frequently told to evaluate patients at a level beyond their level of expertise, after which physicians do not take the time to check their work thoroughly. This leads to poor care of the inmate.

These shortages of staff presumably contribute to the fact that newly arrived patients are frequently not evaluated within 24 hours of their arrival at Springfield.⁸

⁶ SNL 12/23/90.

⁷ DMN 6/28/89.

⁸ DMN 6/28/89.

⁹ DMN 6/28/89.

Moreover, Springfield relies very heavily on licensed practical nurses rather than registered nurses to provide care. The Bureau's reliance on nurses with a lesser level of training exacerbates the effects of a serious nursing shortage. During interviews with prisoners at Springfield in April and May of this year, we received a number of complaints that suggest that nursing shortages have seriously affected the quality of care provided. Patients told us that some nurses refused to record and follow up on patient requests for medical care that should have been relayed to physicians. There were also complaints that, in a disturbing number of cases, patients were given medication that was not prescribed for them or were given an incorrect dose. Until this office complained about the practice, Springfield was using patients of the facility with diagnosed mental illnesses to act as ward attendants for other prisoners. Unfortunately, when the mental patients were fired, apparently no other staff were hired, so that the chronically ill patients who need assistance in bathing, dressing, and other areas now have even less assistance.

On Friday, January 15, 1987, Eugene Fields, a patient at Springfield, suffered massive internal bleeding. That evening, the nurses on duty found Mr. Fields in unstable condition and in need of more care than they could provide. They called the medical officer on duty and persuaded him to authorize a transfer to a downtown hospital. The admitting doctor at the downtown hospital described Mr. Fields as being five minutes from death at the time

he arrived.¹⁰ In another case, a Springfield doctor discovered on a Friday that Nick Pirillo, who had arrived the previous day, had gangrene. The doctor transferred Mr. Pirillo to a downtown hospital for immediate surgery. The next day the outside hospital amputated a portion of Mr. Pirillo's leg. The Springfield doctor's efforts to limit the extent of the amputation by authorizing a weekend transfer for immediate surgery resulted in a letter of reprimand from Springfield's chief physician.¹¹

Quality of Staff

But the quantity of staff is far from the only issue; the quality of staff is equally important. Reportedly three of the thirteen doctors currently on staff at Springfield are not certified by medical boards.¹² The physician who served as chief anesthesiologist failed the written tests for specialty board certification three times.¹³ At least two other physicians have complained about the failure of the current chief of surgery at Springfield to provide minimally adequate health care. Dr. William Hardman, a board-certified vascular surgeon who has served as a consulting physician at Springfield, said that the chief of surgery's knowledge and techniques are perilously outdated and that

¹⁰ DMN 6/25/89.

¹¹ DMN 6/28/89.

¹² WP 6/14/91.

¹³ DMN 6/26/89.

he "has no business operating."¹⁴ One Springfield outside physician indicated that the Springfield Medical Facility surgeons would be stripped of their privileges at local hospitals if they provided the type of post-operative care that is being given today at the center.¹⁵ Two former Springfield physicians said that their former colleagues performed surgery for which they were unqualified, and that no effective system of peer review existed at Springfield.¹⁶ Some members of the operating staff were so concerned about the qualifications of one surgeon that they filed protests to the administration regarding the death of one of his patients. The administration limited the types of operations the surgeon could perform.¹⁷

There is evidence that patients have been harmed by the lack of skill of the staff. Lawrence Manson had surgery at Springfield to remove a cancerous spot from his lung. In error, the surgeon stapled his trachea shut so that he could not breathe. Emergency efforts to repair the error failed, and the patient died on the operating table.¹⁸ Ronnie Holley lost functional use of his penis after the current chief of surgery botched his operation, and as

¹⁴ DMN 6/26/89.

¹⁵ SNL 12/23/90.

¹⁶ CBS, 60 Minutes, 3/17/91.

¹⁷ DMN 6/25/89.

¹⁸ DMN 6/25/89.

a result, the Bureau of Prisons had to pay a substantial award in damages.¹⁹ The Department of Justice has begun a criminal investigation into the death of Eddie Bishop Jones, a severely diabetic prisoner who had complained of a lack of treatment, and who died after being subdued by guards in his cell at Springfield in December 1990.²⁰

When the National Prison Project interviewed patients at Springfield, we received numerous similar complaints. One patient indicated that prior to his transfer to Springfield, a physician had diagnosed a kidney tumor. The physician reportedly indicated that the tumor should be biopsied, and whether or not it was malignant, it needed treatment because it was causing high blood pressure. Following prolonged ground transport, the patient arrived at Springfield where neither a biopsy nor treatment has yet been performed. In addition, the patient has developed swollen lymph nodes, and the cause of this symptom has also not been diagnosed.

In another case, a patient stated that an outside doctor had performed a state-of-the-art and minimally invasive brain biopsy. He states that a Springfield physician initially insisted on a second, highly invasive form of biopsy of his malignancy, and the patient had to arrange for his outside physician to persuade the

¹⁹ DMN 6/4/91.

²⁰ WP 6/14/91.

Springfield doctor not to perform an unnecessary and dangerous medical procedure. Ironically, after the patient persuaded the Springfield doctor not to repeat the biopsy, Springfield failed to treat the cancer. Radiation therapy was delayed for months, until the patient was suffering hundreds of seizures in a single weekend.

Patients also alleged that a particular dialysis patient at Springfield developed a flu, but the dialysis process was not adapted to his tissue loss, with the result that the machine failed to remove enough fluid. Following dialysis, the patient apparently experienced heart failure resulting from the excess fluid. Other patients believe that the patient was not given a second dialysis because none of the nurses was willing to work overtime. A short time later, the patient collapsed, requesting oxygen. Reportedly there was no oxygen on the ward and the patient was told that he could not be moved until count cleared. The patient allegedly died shortly after he was finally moved from the ward.

Royland Randell was transferred from the U.S. Penitentiary-Marion to Springfield for treatment of high blood pressure and an enlarged heart. On June 30, 1991, he complained that his legs hurt. Despite Mr. Randell's complaints, no medical staff entered his room for about five hours. On July 1 he complained that his legs were numb. These were obvious symptoms, particularly in a patient with his medical history, that should have alerted staff to the possibility of imminent heart or kidney failure. That night Mr. Randell reported that he could not urinate; he was found dead

on the floor the next morning. During the two days prior to his death Mr. Randell had been frantically calling for help and yelling that he was dying. The preliminary autopsy found an enlarged heart, clogged arteries and kidney problems.²¹

In-house surgical and post-surgical care is widely feared by patients in Springfield. While the recent decision by Springfield to limit in-house surgery is a step in the right direction, it does not address the quality of post-surgical care within the facility. Among the examples of post-surgical care that were reported to the National Prison Project during our visit were the inappropriate turning of a patient, resulting in the need to reoperate on him, and the failure to monitor a serious bleeding episode in a diabetic patient. A large number of diabetic patients complained of the care of wounds and infections, whether resulting from surgery or other causes. Several dialysis patients reported a delay in appropriate responses to infected dialysis shunts.

Of course, the quality of other care providers besides physicians is also critical to maintaining adequate health care. Many patients at Springfield indicated to my office that nurses were not performing nursing functions. For example, patients or their prisoner attendants were required to change surgical dressings for the nurses.

²¹ St. Louis Post-Dispatch, 7/10/91.

There were also a number of complaints of specific incidents in which a prisoner attendant or another patient informed a nurse of a medical emergency, and the nurse failed to respond in a reasonable time. In one of these cases, when the nurse finally responded, she allegedly refused to acknowledge that the patient was experiencing a heart attack. When she finally decided that the man was not faking, she reportedly returned to her station and called a "code blue" but did not return to assist the patient. The patient died.

The questions about staff qualification are not, of course, unique to Springfield. For ten years the only physician at the U.S. Penitentiary at Marion had no license to practice medicine, because the Bureau does not require that its physicians be licensed.²² Other doctors throughout the Bureau's health care system lack American medical training or board certification in their specialty. A foreign-trained physician at FCI-Lexington lost his medical license after the state licensing board concluded that he had failed to provide proper care to a prisoner, with the result that the prisoner's leg required amputation.²³ For thirteen years the Bureau fought a lawsuit regarding the death of a prisoner at the Terre Haute facility. The doctor, who had never seen the patient, had ordered over the telephone the administration of a

²² CBS, 60 Minutes, 3/17/91.

²³ DMN 6/25/89.

drug, and the patient died from the drug administration. Finally in 1989 the doctor resigned from the facility under pressure from the warden.²⁴

A major problem of the system is its failure to take seriously the health complaints of individual prisoners, too often with tragic results. For five months, Larry Allphin complained of nausea and abdominal pain to a physician's assistant at the U.S. Penitentiary at Terre Haute. Only after he had urinated two pints of blood in a matter of hours did he see a doctor. Two years later he died of cancer.²⁵

In February, 1989 John Chaffee began to complain to prison officials at FCI-Phoenix about his excruciating headaches and other symptoms. A physician's assistant refused to allow him to see a doctor on the ground that the illness was "all in his head." In May he was placed in isolation, allegedly for continuing to complain. On June 7 he collapsed in his cell. Six days later he died of a brain tumor.²⁶

Isabel Suarez had her medication for epilepsy confiscated at the Metropolitan Correctional Center-Chicago. She began to have grand mal seizures and to foam at the mouth. As a result, the staff put her in a (disciplinary) isolation cell. Another prisoner

²⁴ DMN 6/25/89.

²⁵ DMN 6/25/89.

²⁶ DMN 7/27/89.

called an ambulance from a pay phone, but the staff refused to allow the ambulance in. Only after Ms. Suarez went into a coma was she examined by a doctor. Two weeks later, she died.²⁷

The failure to diagnose promptly has its parallel in failures to treat and monitor. Danny Ranieri was blinded by a doctor at FCI-Lexington after the doctor prescribed medication in greater amounts than recommended by the manufacturer and failed to monitor the medication.²⁸

The Medical Transport System

There are some other specific areas of health care that need addressing. One of the most critical is the transportation of medically compromised patients. Although the Bureau has taken some steps to address this concern, it remains one of the most serious of the Bureau's health care problems.

While the Bureau can and does transport some prisoners for medical treatment by plane or ambulance, other prisoners in need of medical treatment are simply handed over to the Marshal's Service, where they are chained to bus seats for hours at a time, have limited access to toilet facilities, and may spend weeks in transit. In one particularly horrifying case, Vinnie Harris died of asphyxiation during his transport after a guard taped his mouth

²⁷ CBS, 60 Minutes, 3/17/91.

²⁸ DMN 6/25/89.

shut with duct tape, supposedly after Mr. Harris complained that he needed to use a bathroom.²⁹

An instructive example of the suffering caused by this system of transport is the case of Clement Messino, who had earlier undergone bypass surgery after a heart attack. He was shipped by bus from Springfield to Sandstone, Minnesota. Instead of being transported north, however, his route took him through El Reno, Oklahoma and then Terre Haute, Indiana. In Terre Haute, Mr. Messino was given oxygen. Then he was put on a 19-hour bus ride to Sandstone during which the temperature was over 100°. At Sandstone, the doctors determined that he had severe heart disease, and needed treatment at a prison medical facility. He was then shackled and driven to Oxford, Wisconsin. From Oxford he was driven to Chicago. In Chicago he spent six hours parked on a bus outside the prison while he experienced chest pains. The next day he was shipped to Terre Haute, where he was locked up in administrative segregation. While in administrative segregation he suffered a heart attack that led to his hospitalization in intensive care for a week.³⁰

August Mazoros died of cardiac arrest twenty-four hours after he was subjected to a twelve-hour bus ride from Springfield to

²⁹ DMN 6/25/89.

³⁰ DMN 6/27/89.

Rochester, Minnesota.³¹ Dr. Martha Graham, Chief of Medicine at Rochester, confirmed that Mr. Mazoros and several other prisoners who arrived on that bus were "very ill" and several died within a matter of weeks.³² A critically ill prisoner who was experiencing bleeding around his brain was sent more than 300 miles by ground ambulance to Springfield.³³

Seriously ill prisoners remain subject to this form of "diesel therapy," as it is commonly called. I began my testimony by describing one such incident; unfortunately, it appears that little has changed in the two years since then. The National Prison Project was recently contacted by an HIV-infected female prisoner who was sent from the D.C. jail into the federal system. She spent over three weeks traveling from one county jail to another. During two of those three weeks, she did not have access to her prescribed medicine, AZT. Despite the stated Bureau policy not to segregate HIV-positive prisoners, this woman was segregated in every county jail she stayed in en route to the federal system.

The inherent danger of sending seriously ill people on cross-country bus trips is aggravated by the fact that patients are sometimes deprived of their medications during transport. This can result in serious exacerbation of the medical problems that led to

³¹ DMN 6/25/89.

³² DMN 6/27/89.

³³ DMN 6/25/89.

the decision to transfer them to Springfield. In at least one case, the deprivation of blood pressure medication may have been a major cause of kidney failure, leading to the necessity of dialysis.

Medical Records

The transport system also contributes to the specific problem that prisoners are frequently transferred without necessary health care records. While the Bureau has taken other steps to reduce the inappropriate use of indirect bus service for transporting sick prisoners, the problem of prisoners arriving without medical records has not been effectively addressed.

Medical records often do not accompany patients, even emergency patients, during transfers.³⁴ Dr. Dante Landucci, a staff physician at Springfield, drafted a memorandum in October 1988 reporting the following:

This week alone I have seen two consecutive, supposedly emergency admissions for whom there was absolutely NO current records despite their having only recently been released from community hospitals.³⁵

On another occasion, Dr. Landucci noted that the patient arrived with so little documentation that "it was impossible to know where he came from, let alone what was wrong with him."³⁶ Glenn Puckett

³⁴ DMN 6/25/89.

³⁵ DMN 6/27/89.

³⁶ DMN 6/25/89.

was transported to Springfield without records, where staff suspected a blood infection. Twelve hours later he died of a diseased liver.³⁷

The National Prison Project's trip to Springfield documented numerous additional complaints that medical records were not transferred with the patient. In some cases, this meant that invasive tests had to be repeated or the lack of records delayed necessary treatment. For example, one patient indicated that his dialysis was delayed because records showing that he had been on dialysis at the time of transfer were not sent. Another patient indicated that, because his medical records were not available, his blood pressure medication was changed, causing serious problems.

AIDS

One of the most critical areas of health care in a corrections population is the situation of persons with AIDS. Prisoners in general have a far higher rate of infection with HIV (the AIDS virus) than the general population of the United States.³⁸ AIDS is a devastating disease, and failure to provide care that meets community standards results in untold unnecessary suffering and premature death. Unfortunately, the reality is that prison health care has rarely even approached community standards anywhere. A

³⁷ DMN 6/27/89.

³⁸ T.M. Hammett, et al., 1990 Update-AIDS in Correctional Facilities: Issues and Options 17, 21 (1991).

study in the New York penal system found that prisoners with AIDS lived about half as long following diagnosis as persons in the community. Significant differences remained even after variables such as race, gender and presumed risk factor had been eliminated.³⁹

Because it is so important that AIDS patients receive care that meets community standards, it is distressing that the same problems that exist in other areas have been documented in this area also. Several AIDS patients died at Springfield within 48 hours after bronchoscopies, a relatively minor surgical diagnostic procedure. This is a death rate far higher than expected for this procedure.⁴⁰ Another AIDS patient died at Springfield after a nurse unsuccessfully attempted to aspirate him. Reportedly a prisoner worker finally aspirated the patient. The patient died that night.⁴¹ A former doctor at Springfield reported that an AIDS patient was so severely undermedicated for pain that he attempted suicide.⁴²

These failures of care at Springfield are particularly disturbing in light of the fact that the Bureau has always

³⁹ R.L. Gido, et al., Update Acquired Immune Deficiency Syndrome: A Demographic Profile of New York State Inmate Mortalities 1981-1986 27-28, 30 (1987).

⁴⁰ SNL 12/23/90.

⁴¹ SNL 12/23/90.

⁴² DMN 6/26/89.

maintained that any limitations on the care of AIDS patients at the smaller Bureau facilities are fully compensated for by the ability to transfer AIDS patients to Springfield. For example, a federal court in Florida found that MCC-Miami was unable to provide the appropriate medical care and continuity of treatment necessary for AIDS patient Leonardo Gomez.⁴³ Ironically, the Eleventh Circuit Court of Appeals reversed the order of the district court based on representations by the Bureau of Prisons that adequate care was available in Springfield.⁴⁴

An important part of the care of HIV-infected prisoners is comprehensive AIDS education and psycho-social support. According to a recently released National Commission on AIDS report, "AIDS prevention programs remain the single most effective strategy for slowing the spread of HIV infection."⁴⁵ However, the National Prison Project's AIDS Project reports that prisoners in the federal system commonly complain that little or no AIDS education or support is available, either at Springfield or elsewhere in the system. In fact, the only two programs at Springfield that we are aware of were initiated and developed by prisoners. Reports from

⁴³ Gomez v. Bureau of Prisons, 89-1862-Civ-Spellman (S.D.Fla. 11/17/89).

⁴⁴ Gomez v. U.S., 899 F.2d 1124, 1126 (11th Cir. 1990).

⁴⁵ National Commission on Acquired Immune Deficiency Syndrome Report HIV Disease in Correctional Facilities, March 1991, p.21.

three other federal facilities indicate that there was no AIDS education until peer support groups were set up by prisoners.

Mental Health Care

As noted earlier, as of June 1991 only one of the seven psychiatrist positions at Springfield was filled.⁴⁶ One can only wonder how a single psychiatrist can possibly be expected to manage over 230 psychiatric patients. It is unclear how one psychiatrist could even monitor the psychotropic medications of this many patients effectively, let alone attend to the psychiatric needs of the rest of the hospital population. A number of psychiatric patients are constantly sedated;⁴⁷ it is hard to suppress the suspicion that fewer patients would require sedation if an adequate treatment program were in place.

Lack of proper staff supervision of mental patients also seems implicated in several tragic incidents at Springfield. In October of 1990, a psychiatric prisoner at Springfield gouged out his eyes while medical center personnel were only a few feet away. The Bureau did not conduct a formal investigation. In 1988 a Springfield psychiatric prisoner ate the contents of his colostomy bag and choked to death.⁴⁸ There reportedly exists a videotape of

⁴⁶ WP 6/14/91.

⁴⁷ WP 6/14/91.

⁴⁸ SNL 12/23/90.

this incident, showing that the prisoner's actions were watched by nearby staff who failed to respond.

When my office visited Springfield, we found that mental patients are receiving little in the way of group or individual therapy. Seriously ill prisoners are confined in stark strip cells and sometimes placed in mechanical restraints. By far the most prevalent form of treatment appears to be prescribing psychotropic medication. Very little in the way of programming exists.

Ironically, one of the few programs available for the mentally ill was work as ward attendants for other chronically ill patients. For a substantial period of time, there has been a consensus among correctional medical care providers that prisoners should not have any role in patient care for their fellow prisoners.⁴⁹ The Bureau's use of mental patients for this role, while abandoned after complaints from my office, was wholly inappropriate.

Unfortunately, no substitute programs or jobs were established when these jobs were abolished.⁵⁰ The Bureau desperately needs an organized, properly staffed psychiatric program at Springfield capable of attending to treatment needs beyond the prescription of psychotropic medication.

⁴⁹ See, e.g., National Commission on Correctional Health Care, Standards for Health Services in Prisons, Standard P-23, p.13 (1987).

⁵⁰ Nor were other civilian staff hired to give whirlpool baths, lift and turn patients, and perform the other functions that had been performed by the ward attendants.

Other Systems Problems

Several patients at Springfield complained to our office that dialysis patients are given inadequate care. Patients alleged that the dialysis unit was not appropriately supervised, so that unexpected events, such as episodes of patient bleeding, were not given a prompt response.

In addition, since 1986 the Bureau has refused to allow patients to have kidney transplants under any circumstances. In some cases, the patient's family has attempted to arrange a transplant of a kidney from a family member, but the family has been thwarted by the Bureau's refusal to cooperate.

In our interviews at Springfield, we learned that some patients appeared to be receiving less than adequate care for complications of their diabetes. For example, some patients alleged that problems with inadequate circulation in their feet had been essentially untreated at Springfield, resulting in serious deterioration that could lead to amputation.

There were also allegations that pain medications from outside physicians were frequently altered, resulting in inadequate pain relief. Necessary physical therapy and speech therapy for stroke victims and others are not always provided. Several of the medical diets were reportedly seriously inadequate, and diabetics on locked wards feel that the deprivation of exercise harms their health. Mentally ill patients are sometimes punished for actions that

result from their illness, such as the reported case of an Alzheimer's patient who was repeatedly punished for smoking.

Necessary Steps to Improve Health Care in the Bureau

The first step that the Bureau must take is to promulgate a policy that all health care providers must be fully licensed for the health care functions they perform. The use of unlicensed physicians is unconscionable and must cease immediately. In addition, the Bureau needs to provide by policy that no prisoner is to be used to provide a health-care related service to another prisoner. In addition, the Bureau immediately needs to secure the services of a recognized expert in evaluating correctional medical care to perform a full-scale medical evaluation of care within the Bureau. The resulting Report should include, among other issues, the following:

(1) The Report should resolve in a medically appropriate manner the unique logistical problems faced by the Bureau in transporting patients, including a guarantee that patients will not be transported without necessary medication or medical records.

(2) The Report should develop a recommendation for a meaningful system of quality and peer review. The National Prison Project recognizes that the Bureau complains that the traditionally poor reputation of correctional medicine exacerbates the problem of obtaining and retaining qualified staff. But hiring and retaining substandard medical staff only perpetuates the problem.

Vigorous peer review equivalent to community standards will enhance the prestige of health care providers within the Bureau, and in the long run make it easier to attract quality staff. On a related point, the Report should address whether low salaries at the Bureau contribute substantially to problems in health care.

(3) The Report should address whether the Bureau should reduce substantially its reliance on in-house staff for complex medical procedures. Given the Bureau's current problems, such as surgical care at Springfield, it may well be that the safest and most economical route to providing decent health care is to phase out most in-house surgery and similar procedures, and rely on contractual services from community providers. This step would be consistent with the recent reduction of in-house surgery at Springfield.

(4) The Report should set out guidelines requiring the Bureau to treat serious medical needs. Certainly a patient in need of a kidney transplant has a serious medical need, and the Bureau is arbitrarily failing to meet that need. Kidney transplants are not experimental, and they are routinely covered by medical insurance.

(5) A psychiatric consultant with experience in corrections mental health care should also be retained to prepare a similar report addressing mental health care within the Bureau.

The National Prison Project recognizes that two years ago the Bureau did have a review of its health care performed by Richard Wilbur, M.D. Some of the findings of that report are consistent

with these recommendations. For example, Dr. Wilbur found that the Bureau does not have a well-defined overall health mission that is clear to those who deliver health care.⁵¹ He also found that the Bureau seemed to lack a system of collegial review of one physician's work by another physician from outside that institution.⁵²

However, Dr. Wilbur was not experienced in corrections medicine and his report is accordingly deficient in failing to address issues unique to the corrections setting. For that reason a new, and comprehensive, review of the system is necessary.⁵³

Finally, there is another dimension of the problem that must be addressed. One of the most frustrating aspects of dealing with health care issues in the Bureau is the Bureau's defensive attitude. This attitude was on display in CBS' "60 Minutes" feature regarding health care, in which Bureau spokespersons simply refused to acknowledge the possible existence of problems. I have repeatedly encountered a similar response from the Bureau in attempting to address the health problems of individual prisoners.

⁵¹ Richard Wilbur, Preliminary Bureau of Prisons Quality of Health Care, pp.1-2.

⁵² Id. at 10.

⁵³ This office offered to supply the Bureau with a recognized corrections medical specialist to perform a standard evaluation of the medical care offered patients at Springfield. Although Director Quinlan had earlier endorsed the idea of a review of Springfield medical care by an independent corrections medical expert, the Bureau refused to agree to the inspection.

Until the Bureau is willing to acknowledge its problems, improving the health care system will prove unnecessarily difficult.

Conclusion

On June 25, 1989, Olive Talley of The Dallas Morning News reported that the News' year-long investigation of Bureau health care "reveal[ed] a medical system plagued by severe overcrowding, critical shortages of doctors, nurses and physician's assistants, and life-threatening delays in transfers of inmate patients to major prison hospitals."³⁴ Unfortunately, the intervening two years have not shown that the Bureau is able to solve its own problems, and it is now time for Congress to exercise its oversight responsibility.

³⁴ DMN 6/25/89.

Mr. HUGHES. Dr. Thorburn, welcome.

**STATEMENT OF KIM MARIE THORBURN, M.D., MEDICAL
DIRECTOR, HAWAII DEPARTMENT OF PUBLIC SAFETY**

Dr. THORBURN. Thank you, Mr. Chairman, for this opportunity to testify on a topic that is near and dear to my heart, such that I've chosen it as my career profession. I will highlight a few comments in my written testimony, and I also want to deal with a couple of issues that I've heard raised in questions earlier this morning.

First of all, we've talked a lot today in the hearings about the burgeoning prison population, and I think we also need to emphasize, with the growth of the prison population has been a change in the demographics such that it's affected the health of the prison population. Now that we've hypercriminalized substance abuse and more and more people are coming into our prisons for long periods of time with histories of substance abuse, and also with the longer sentences, we're seeing a change in the diseases that we used to care for when we had a younger prison population.

Communicable diseases, such as HIV infection, tuberculosis, and hepatitis, are devastating our populations. Mental illness is extremely common, much more common in prison populations than it is in the general community. Addiction needs to be dealt with. Currently, only 5 percent of the prisoners throughout the Nation have access to substance abuse treatment programs while they're incarcerated. And, then, as the population ages, we're also facing chronic degenerative diseases that are seen with aging at a much greater rate than we used to.

The problem is our systems have not been set up to deal with these kinds of health problems. This morning we heard Director Quinlan and Dr. Moritsugu talk about overuse of their health care system, and they talked about creating disincentives to the overuse. I'm very concerned about this concept.

It is, in fact, true that our health care systems in the correctional setting are used a lot, and this can be very taxing to health professionals who work in the system. I'm also professor of medicine at the University of Hawaii. When we want to present malingering to medical students, they usually use a prisoner case. I have to confess I think when I started to work in the prison system, I felt that probably malingering was going to be a common medical problem that I would deal with.

Over the years I've come to realize that the overuse of the system is not because of manipulation and malingering in most cases. We heard from all three prisoners who testified their fears, fear of the health care system, and they personalized it, but my sense is that prisoners are afraid that they're going to have some serious health event while they're incarcerated and may, in fact, die. Prisoners have a great fear of dying behind bars.

What I see as the cause of the overuse of the system is a testing of the system. Prisoners want to know if the system is going to get to them if they really need it, if it's going to be able to provide for them. I think that setting up disincentives is only going to feed into this fear. Really what we need to do is prove to prisoners that our

systems are accessible to them. Sick call just is not a very good method of proving to prisoners that the systems are accessible.

When we have sick call in most systems, usually you have to make your request to some low-level professional, and it works its way up. We hear in the Federal Bureau of Prisons, as in most systems that use physician assistants, that the physician assistant is the one who will make the decision about whether or not that needs to be referred on. This can be a wall to appropriate services or it can be perceived as a wall. What happens, then, is this constant testing of the system by the prisoners.

And, this is why I talk about systems of primary care and preventive health care as a revision to the current use of sick call, meaning that we do regular health screening. We heard that they do physical examinations on intake. Because of the degree of illness in our population, physical examinations have to be done more than once in 20 years, if that's what the sentence of the prisoner is. We need to do regular physical examinations, regular health screening, and let the prisoners know that we are reaching out and that they can access health services when they need them.

Another method that I've used with my staff to prevent burnout from these occasionally manipulative prisoners is to have case conferences about difficult patients and to set up a regular appointment with a person who is constantly coming to us with different kinds of complaints, and let this inmate know that we will see you on a regular basis. We're going to set the schedule. We'll see you in between if there is a real emergency, but we will see you at regular intervals, so that he doesn't have to feel that he has to keep constantly coming to us with requests.

We've also heard a lot about staffing problems, that staffing levels are insufficient. I want to focus on two issues about staff, and that is qualifications and also our tendency in our systems to use health care staff inappropriately. We heard this morning that all physicians in the Bureau are licensed. However, they are not necessarily licensed in the State in which they practice. Licensing is regulatory and it's a State responsibility. The reason for licensing professionals is to put some requirements on the practice of that profession. The requirements do vary from State to State.

But, for example, I'm licensed in California and Hawaii. In both those States, I have a requirement to meet a certain number of hours of continuing medical education, another issue that came up. If I were practicing in the Federal system, I get the feeling that I wouldn't be required to meet those regulatory mandates. So, I'm concerned when I hear that the Federal system is not requiring that the physicians be licensed in the jurisdiction in which they're practicing. I'm wondering if they're needing to meet the regulatory requirements.

I also am concerned when I hear that physician assistants are not certified. Again, this is another way of ensuring that they meet certain requirements.

What we haven't heard talked about is inappropriate use of staff, and I did make some reference to this in my written testimony. There is a tendency to have health professionals work beyond their scope of training and regulated practice. The commonest example I see in our systems is nurses. We use both registered professional

nurses and licensed practical nurses. In most systems that I've looked at the duties of these two nurses are not distinguished. They practice the same. Yet, there's a good deal of difference between the training of a professional nurse and a practical nurse, and there really should be distinctions in the duties and different levels of supervision that occur.

I was pleased to hear that the Bureau is moving forward on their quality assurance programs. As I mentioned in my written testimony, quality assurance monitoring is fairly new to correctional medicine, and we're always striving to build our program.

One of the intents of quality assurance monitoring is to have an idea about the outcomes of your services. We heard Director Quinlan say that in community hospitals 4 percent of health care occurrences result in an unexpected results. And then he was always saying, "We meet the community standards," but I didn't hear him indicate whether or not it was 4 percent of occurrences resulting in unexpected results within their system. That's what a quality assurance program needs to tell the Bureau and all of us. They need to set up indicators to monitor, so that they can come before the committee and make a comparison other than just a broad statement of "We meet community standards." A quality assurance program is set up to come up with those kinds of hard, objective outcomes.

You raised a question about clinical autonomy of the physicians and other health professionals. This is a very, very important issue for those of us who work in an institutional setting like prisons where the whole purpose of the institution is so very different from our profession. I mean, we care for people and prisons punish people. That is going to sometimes put us in a position of, "Who is our boss and what are our responsibilities?"

I'm the president-elect of the American Correctional Health Services Association. This is the professional association of health professionals who work in correctional settings. We're actually struggling with this issue. We've come to the realization that we need a code of ethics for health professionals who work in this setting, because we're constantly faced with these questions of professional responsibility and ethical responsibility. I give workshops on ethics for correctional health professionals in national conferences, and they're always the most attended. Being clear about reporting is essential in order for us to be clear about our professional responsibilities.

There was also a question about cost containment that came up earlier. Health care is going to be a very costly part of prison systems, especially with the direction that we're going, as I alluded to, incarcerating people who are sick. I think that that's something that has to be considered in terms of passing sentencing laws and crime packages.

I would just like to let you know about something that we've done in the State of Hawaii. Prisoners are not eligible for Medicaid coverage. The Federal law excludes them. There was some talk among prison officials to try to amend that law to make prisoners eligible, and the reason for the interest in such an amendment is that many systems have no way of controlling costs for outside services.

When I came to Hawaii, there was a limited number of outside facilities that we could access for prison health services. So, when I went to them to try to negotiate contracts and cost savings, I couldn't do that. They were already charging us top rates for the services, and they had no incentive to negotiate with me for some sort of cost containment contract.

So, we passed a law to make prisoners eligible for State medical assistance. Basically, what that does is cap our costs for outside services at Medicaid rates. We've had a considerable cost savings as a result of that.

One of our concerns was that we would lose outside providers, and that hasn't been the occurrence. We've still found that all of our outside providers have been quite willing to provide us, even with this cap.

I'd be happy to answer questions.

[The prepared statement of Dr. Thorburn follows:]

PREPARED STATEMENT OF KIM MARIE THORBURN, M.D., MEDICAL
DIRECTOR, HAWAII DEPARTMENT OF PUBLIC SAFETY

July 17, 1991

To: Congressmen William J. Hughes, Chairman

Subcommittee on Intellectual Property and Judicial
Administration

From: Kim Marie Thorburn, MD

Chairman Hughes, members of the Subcommittee on Intellectual Property and Judicial Administration, thank you for the opportunity to testify about health care in prisons. I come before you with a dozen years of experience as a physician, first in California prisons and for the past four years, as the health care director of the Hawaii correctional system. I am president elect of the American Correctional Health Services Association (ACHSA), an interdisciplinary organization of health professionals who work in correctional facilities. As an internist, I am active on the Human Rights and Medical Practice Subcommittee of the American College of Physicians (ACP). The ACHSA and the ACP are joining the National Commission on Correctional Health Care (NCCCHC) in the preparation of a joint statement to express concern that health services in the nation's correctional facilities are not keeping up with inmates' health needs. My comments will reflect problems facing health services throughout the nation's prisons and jails, many of which also apply to the Federal

prison health

Thorburn

Bureau of Prisons.

Recent improvements in correctional health services are threatened by the nation's burgeoning prison population. Beginning in the 70s, civil rights litigation and involvement by organized medicine forced community standards on prison and jail health services where medical neglect had been the norm. The problem is that health services, a costly component of prison budgets, are not being sufficiently funded to maintain these standards during this period of rapid prison population growth resulting from the National Drug Strategy of criminalizing drug use, rejection of alternatives to incarceration and longer sentences. Prison expansion costs tend to be calculated as the costs to build beds and provide security rather than the total costs, including health care.

There are no published staffing formulas for health services in prisons. Consequently, prisons expand and new facilities are built with attention to security staffing but health care staffing needs are neglected. As governments tighten belts, this problem becomes even more acute. Expenditures for health services and medical supplies are also jeopardized. I am aware of one state whose prison population grew by one third in a year and yet no new health care positions were budgeted. Another state eliminated its quality

prison health

Thorburn

insurance program when travel allotments were restricted and reviewers could not travel to monitor institutions.

Prison populations are, at the same time, becoming sicker. Diseases associated with poverty and substance abuse are prevalent among prisoners. AIDS has been overwhelming prison health systems since early in the epidemic with an aggregate annual incidence in state and federal prison systems that was more than 15 times the community incidence by the end of 1989. Tuberculosis and hepatitis never saw the degree of eradication in prisons that occurred in the community and now, as these communicable diseases resurge in some communities, the problem for prisons grows even more. Mentally ill people are overrepresented in prisons, reaching rates of 10 to 15% in some facilities. Addiction rates among prisoners are 60 to 80%. Prisoner populations are aging which signifies more chronic degenerative diseases than were prevalent when our prisons were filled almost exclusively with young men.

The traditional organization of health services does not prepare them to meet these health care needs. The typical delivery model is a reactive system of care on demand: sick call. Health services are requested rather than scheduled. Such a system does not lend itself to regular follow-up care which is needed to manage of chronic diseases.

prison health

Thorburn

Primary care and prevention models of health care delivery have not been emphasized in correctional systems. Even when health screening is performed, systems are not capable of following up on abnormal findings. I saw this recently in a system that performed extensive dental examinations on intake of inmates but did not have the organization and resources to carry through on identified treatment needs. Primary prevention systems, like health education and vaccination programs, are often totally lacking.

These problems are compounded by the fact that recruitment and retention of qualified health care staff are, at best, a time-consuming challenge for any prison health administrator. The discontinuation and eventual loss of the National Health Service Corps as a source of physicians for prisons and jails removes a major supply of doctors. The national nursing shortage means that correctional institutions are competing with other health care facilities for scarce resources. Aside from the perception of prison health services as undesirable work sites, the location of many institutions in rural areas is not attractive to health professionals. A sense of isolation can lead to professional dissatisfaction and resignation, even when correctional health is a career choice.

To make up for staffing shortages, correctional health

prison health

Thorburn

services tend to hire unqualified health care workers, often nonprofessionals without licenses or certification, and have them work beyond their scope of training and education. Three examples of this practice are physicians assistants, practical nurses and psychologists. Some systems, including the Bureau of Prisons, rely heavily on physicians assistants as primary caregivers. Inmate patient complaints are triaged through a series of health care workers who decide if referral to the next level of worker (or professional) is necessary. Improper diagnosis and decision-making may result in inadequate care by an unqualified worker.

Nursing positions in correctional settings are often filled with practical nurses. Nurses may also be principle providers and function with considerable autonomy. Duties of practical nurses tend not to be distinguished from those of professional nurses. Practical nurses with clinical training and education perform assessments and treatments without the necessary skills to do so.

For psychology services, some correctional systems hire people with bachelors degrees in psychology or nonlicensed masters degree psychologists. The need for mental health services in correctional facilities is extensive and challenging. Skill and experience of the professionals is

prison health

Thorburn

essential to ensure adequate services. Nonlicensed mental health workers may lack training to deal with complex inmate mental health needs.

Salaries for health professionals in correctional institutions are often not competitive with private sector. One solution in correctional systems has been to assign health care workers with security functions and enhance their salaries with hazard bonuses. Some systems even have health care workers attend training for guards. This role confusion destroys health professional-patient relationships and deprofessionalizes health professionals. Security functions should not be a requirement for hazard salary enhancements for correctional health professionals who daily enter the facilities and face the same dangers as guards. In fact, health professionals may be taken hostage more often than other employees in prisons, as recently exemplified in the Bureau, Illinois and Nevada.

Quality assurance monitoring is a new development in the correctional health arena. Ideally, prison quality assurance programs should include both internal and external monitoring systems. Many prison departments, including the Bureau, have internal monitoring systems in place.

Quality assurance monitoring by groups outside our

Prison health

Inorburn

institutions is less consistently established than internal audits. Accreditation programs, such as the NACCHC and the Joint Commission on Accreditation of Healthcare Organizations, are helpful but they review entire systems. It is also important to have external review of cases. The tendency is to seek external reviews when there are grievances about care but adequate external monitoring systems would establish systematic indicators for review.

The obvious place to turn for external review is organized medicine. However, my own experience with the Hawaii Medical Association is that these organizations are reluctant to become involved because of fear of litigation. Nonetheless, it is incumbent on those of us who administer correctional health services to seek regular outside review and feedback about the care we provide.

I would like to thank you again for this opportunity to testify about some of the issues and problems facing correctional health services today. My recommendations to legislators start with a plea to be cognizant of the results of current incarceration trends. Criminal justice policy is filling our prisons with people with extensive health needs. Yet the policy's effectiveness, especially for eradicating substance abuse, is not proven. If the current frenzied rate

prison health

Thorburn

of incarceration continues, adequate health services must be factored into prison building and expansion. Prison health services should develop primary and secondary prevention programs as a component of the public health system and should serve as entry points for continuing community care. Staffing for our facilities should be by licensed and qualified health professionals and salaries should be competitive enough to attract such professionals. Finally, methods should be sought to induce organized medicine into peer review of our care by minimizing their fear of litigation.

Mr. HUGHES. Dr. Greifinger, welcome.

STATEMENT OF ROBERT B. GREIFINGER, M.D., DEPUTY COMMISSIONER AND CHIEF MEDICAL OFFICER, NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES

Dr. GREIFINGER. Thank you. I appreciate the opportunity to speak before you today and to discuss what I believe is the unique challenge of correctional health care, and to provide recommendations for your consideration for legislative action.

As we all know, inmates are a vulnerable population. They're young, poor, undereducated, and overrepresented by minorities. Their medical problems are distinctive because of the ravages of drug abuse, mental illness, and now AIDS. New York has an especially intense concentration of HIV infection. Fifteen percent of incoming male inmates are infected with HIV, and 19 percent of incoming female inmates are infected with HIV. One-quarter of incoming inmates are infected with tuberculosis, and one-tenth have evidence of recent syphilis. We have, out of 58,000 inmates, over 1,000 with symptomatic HIV disease.

Because incarceration for most inmates is under 2 years, I believe that there's value to our society to take a perspective that looks beyond the period of incarceration. I believe that the correctional environment provides the most fruitful public health investment opportunity in the Nation. I'm trying to develop an argument that will help develop resources for correctional health that can look at the public policy agenda for a public health initiative for society as a whole that can focus on an accessible, but very dynamic population.

To honor the constitutional entitlement for inmate medical care and to maintain this public health perspective is a very complex and challenging task. Moral issues of privacy and discrimination compound the tension between the security requirements and high quality medical care.

Congress can be helpful through legislation and regulation: first, for recruitment and retention of competent professional staff, which has been discussed in detail. Competitive salaries are required, but also attention could be paid to the expansion of mandatory public service programs for health professionals, expansion of programs like the National Health Service Corps to provide young professionals the opportunity to serve their country spending 2 years or 3 years working in a prison or with any of a wide array of other disenfranchised people in the United States.

Correctional health care needs physically modern, well-staffed facilities. Just like salary, a well-staffed, modern facility is imperative for what I call employee hygiene, for helping people feel comfortable where they work, feel that they can act as professionals in an environment that is conducive to professional activity. Antiquated facilities, in particular, are major disincentives for folks who have many other employment opportunities and often at much higher incomes.

Looking beyond the period of incarceration, I believe that people need a universal entitlement to medical care in the community. One of the sad facts of correctional health care is that on the occasions when we do provide excellent, intensive medical care for in-

mate patients, the time comes for their release to the community and there is scant ability to develop linkages for continuity of care for these sick inmates. We have occasions in New York State, not infrequently, where inmates will decline the opportunity to go on parole because they believe they are getting better medical care within the walls than they would be able to access outside. That is certainly true for people who would not be able to get a nursing home bed, for example, or who would not be able to have immediate access to primary care services to continue intense medication regimens or other treatments that they are on.

Compassionate release programs for the terminally ill, I believe, are important not only for humanitarian reasons, but they have economic merit. Terminally ill inmates require medical care, and one might make the argument that they will require medical care when they are on the outside. That is true. So, that would just be a shifting of costs. But, one has to consider that terminally ill inmates are often ill in a hospital, in a community hospital, where the cost of security coverage far exceeds the cost of the hospital bed. So, for that economic reason alone, it makes sense to provide legal conduits for compassionate release.

Quality management instruments are very, very useful, particularly as they can set very clear expectations for medical care, but I would like to emphasize the quality management instruments need to be seen as tools for improvement. They need to be seen from a perspective that nothing is perfect and the mission is to improve quality in an ongoing way. When quality management instruments are used only for oversight or for litigation, they become tremendous disincentives for honest participation by health professionals. If the results of quality management surveys and audits, et cetera, are made available to critics, health professionals will find ways around taking the fullest advantage of those. Quality management is a process, it's a dynamic process that improves medical care through the process and over time.

Leadership and authority for correctional health executives are imperative. Medical directors and their equivalents in the Federal Bureau and throughout the United States need to have leadership qualities, and they must have authority not only to develop policy, but to implement programs which make sense, programs which are efficient and effective for the provision of high quality medical care.

Effective and cost-efficient programs also require a database which can be provided from epidemiologic research. The epidemiologic research is insufficiently funded, and there's insufficient information about the epidemiology of disease within prisons and among inmates. It will be very helpful for correctional health people to have access to more current scientific data about patterns and remedies for the medical care problems of inmates.

In summary, I believe there has been a dramatic change in the nature of inmates' health status during the past decade, not only because of AIDS and mental illness, but also because of the increasing criminalization of drug abuse problems. This change affords us an opportunity that is unique and it's an opportunity for us to serve a broader public interest by making an investment in inmate medical care. I thank you.

Mr. HUGHES. Thank you very much.

[The prepared statement of Dr. Greifinger follows:]

**Testimony on Prison Health Opportunities
House Committee on the Judiciary
July 17, 1991
Robert B. Greifinger, M.D.**

Mr. Chairman, Members of the Committee and staff: I am Robert B. Greifinger, M.D. I have been Deputy Commissioner and Chief Medical Officer of the New York State Department of Correctional Services for two years. I am a Board Certified Pediatrician, and a Fellow of the American College of Physician Executives. I have 19 years experience as a physician executive.

Profile: New York State Prisons

Fifty-eight thousand inmates are in New York State custody in 68 facilities. The growth rate has been eight percent per year, and the inmate population has an annual turnover rate of 50 percent. Last year we touched 81,000 inmates. Ninety-five percent of inmates are male, and the median age is 30. Twenty-two percent have a high school diploma. Fifty percent of the population is Black, and 32 percent Hispanic. Only 15 percent of the inmates have minimum sentences over ten years, and the median time of incarceration upon release is 15 months. Eighty-five percent are released in under 36 months.

The Department's annual operating budget is \$1.2 Billion of which ten percent is spent on medical care. There are 27,000 employees, of whom 1,000 are health professionals.

Health Services Organization

The Department directly operates primary care services in each facility; most have 24-hour infirmaries and on-site pharmacy services. Provision of specialty services varies, including both regional clinics within facilities, and community resources. Acute in-patient care is provided by contract through six secure units in community hospitals, and at 40 other hospitals throughout the state. The Department is developing larger secure in-patient units so as to increase security and enhance access to specialty physician services. Pharmacy services are being regionalized, utilizing electronic prescription transmission and overnight delivery.

This year, the Department opened Waish Medical Center, the first of three long-term care facilities for inmates who do not need acute hospital beds, but who require more intensive services than those provided in facility infirmaries. These regional medical centers will also provide ambulatory specialty medical services.

In 1991, we will have 1.5 million medical and dental visits and fill 1.5 million prescriptions.

Epidemiology

Unique among correctional systems, New York State has 7,500 HIV infected inmates, of whom 1,000 are symptomatic. The incoming HIV seroprevalence is 15 percent among males and 19 percent among females. The mortality rate in 1990 was 30 per 10,000 of which two-third's is attributed to AIDS. In the past decade there have been 1,063 AIDS-related deaths, 16 percent of which have been in the past year.

The AIDS mortality rate has declined by 20 percent during the past two years, attributable to aggressive efforts to voluntarily screen, counsel, and treat high risk individuals. There are currently 1,600 patients on Zidovudine (AZT) and 800 on prophylaxis for Pneumocystis Pneumonia; these are four fold increases from 1989.

Closely related to HIV, are the profound numbers of infections with tuberculosis and syphilis. Twenty-eight percent of incoming inmates have positive skin tests for TB. Eighty inmates have developed active Tuberculosis during the past year. Twenty-five percent of incoming females, and eight percent of incoming males have serologic evidence of recent syphilis.

Most of the medical care programs created in the past several years have focused on the prevention, early detection, and treatment of HIV and its related infections. These efforts are expensive and complicated, but they have economic benefits, not only in lives saved, but in prevention of transmission in the community upon release.

Mission

The mission of health services for inmates is to serve the public trust through socially responsive, compassionate, high quality and cost-efficient programs. These programs must respond to complex and often conflicting demands; many of these conflicting demands are unique to the correctional environment.

For example, there are moral issues of privacy, discrimination, and research which differ from those in the free world. There are constitutional

entitlements to care, as the Eighth Amendment prohibits cruel and unusual punishment, yet inmates are restricted from free choice of provider, diet, and exercise. Security requirements often conflict with access to and compliance with medical services.

Increasingly, prisons have taken custody of the mentally ill, the addicted, and since AIDS, the sick. The institutions have been pushed within one decade to change their very nature; these changes are difficult in any culture, especially in those which are highly structured and contorted into physical space built for populations with other characteristics.

The unifying theme in both prisons and medical care has been education, an opportunity to lead people out of their current situation into a life which is more physically, socially, and spiritually whole. For those detractors who believe inmates are solely incarcerated to be punished, we need to remind them that the great majority of inmates are back on the street within a relatively short period of time. We need to look beyond the period of incarceration. Hence, a Public Health approach to the organization of health services for inmates becomes a compelling model.

1

Public Health as Sound Public Policy

There are various perspectives on correctional health care. Included among them are legal (Constitutional entitlement), religious (universal mission to alleviate suffering), moral, and public health. Viewing inmates as public health sentinels, part of the ecosystem of modern society, is in the public interest.

The correctional environment is the most fruitful public health investment opportunity in the nation. While in custody, the population is accessible, observable, and treatable; it is characterized by high risk: poverty, drug use, undereducation, and overrepresentation by minorities. The return on the investment is realized upon return to the community.

Legislative Agenda - The Role of Congress

Provide through legislation and regulation, public policy and resources to take advantage of a public health opportunity:

1. We need good staff. Recruitment and retention of professional staff is a universal problem. Competitive salaries are imperative. Expansion of programs of mandatory public service for young health professionals can provide a high quality work force, and an unmatched educational opportunity.

2. We need well staffed and physically modern facilities for medical care, improving the work environment for those whose public image is less than deserved. There are clear cost benefits to education and early intervention, especially with the set of diseases which plague inmates. Adequate staffing helps make these happen.

3. We need to look beyond the term of incarceration, to provide for continuity of care on release, through universal entitlement of medical services. We need compassionate release programs for the terminally ill.

4. We need to encourage the development of Quality Management instruments, as devices for quality improvement, not tools for litigation. Expectations are often unclear without defined standards.

5. We need leadership and authority for correctional and health executives, so as to be able to meet increasing and complex challenges.

6. We need support for epidemiologic research, aimed toward the development of effective and cost-efficient programs.

In summary, there has been a dramatic change in the nature of inmate health status. This change affords us a unique opportunity to serve the broad public interest by investing in inmate medical care.

Mr. HUGHES. Dr. Landucci, you've heard testimony this morning from two panels. Director Quinlan acknowledged some shortcomings in the system and desires for improvement. You heard, I'm sure, the three prison inmates that testified today. You've heard testimony from this panel about some of the problems that exist in the Federal system and in penal systems generally. From your own experience, both at the LA facility where you were, I think, the chief medical programmer for several years, and your years at Springfield, MO, at the Bureau of Prisons medical facility, can you give us your impression of the system as you see it?

STATEMENT OF DANTE LANDUCCI, M.D., FORMER CHIEF OF HEALTH PROGRAMS, BUREAU OF PRISONS METROPOLITAN DETENTION CENTER, LOS ANGELES, CA, AND, PREVIOUSLY, MEDICAL OFFICER, U.S. MEDICAL CENTER FOR FEDERAL PRISONERS, SPRINGFIELD, MO

Dr. LANDUCCI. Good afternoon, Mr. Chairman. Before I start to answer that question, I'd like to make one item clear for the record. While your agenda correctly shows me as being employed by the National Institutes of Health, I'd like to make sure that you understand that I am here as a former employee of the Bureau of Prisons, not in any formal capacity with my employment with——

Mr. HUGHES. I understand.

Dr. LANDUCCI [continuing]. DHHS.

Mr. HUGHES. We understand; you're here as a former employee of the Bureau of Prisons.

Dr. LANDUCCI. With regard to medical issues in corrections in general and in the Bureau of Prisons in particular, I have to say that I think a lot of my thunder has been stolen by people who are speaking on this panel and also, to a certain extent, by Mr. Quinlan and Dr. Moritsugu. My intent is to emphasize some of the points that have been made by people before me and maybe elaborate on some issues that haven't been covered.

The foremost thing I can see as being important when a patient comes to me as a correctional medical officer or a health care provider of any sort, is that the individual has to be able to feel that they have a sense of confidence in me, that they can develop trust in me. That is hard to do with an inmate population because of the kind of people that they are, because of the kind of setting that you find yourself in, but it also is made more difficult by the structure of health care delivery within the Bureau of Prisons itself.

The Bureau mandates and makes it openly known that the medical responsibilities of health care providers are really secondary to their correctional responsibilities. Quite frankly, that is just too big a burden on health care providers. It really enhances the inherent distrust and hostility that inmates feel. In the end, inmates feel they need to exaggerate their symptoms in order to access what they feel they must be able to get from the health care system. What then happens is that, because this exaggeration occurs on a regular basis, on a daily basis, with so many encounters, health care providers become desensitized and often, much more often than is probably warranted, label inmates as malingerers. When that happens, that inmate has or those individuals as a whole have, for at least a short period of time and possibly indefinitely,

the door closed to access to adequate health care. It may open again if they come up with a different set of symptoms or a symptom relating to a completely different organ system or process, but it really restricts their potential to get good care.

Clearly, encouraging people to reevaluate—and by “people,” I mean health care providers in all correctional settings—to carefully reevaluate the people whom they have labeled as malingerers is important, but I think it really boils down to the fact that Bureau policy should be changed. It should be very clear that health care providers of all sorts should be allowed to function as independent, and wholly independent, professionals. They should bear in mind correctional issues; they should keep in mind that what they do can affect the safety of other people in the institution. But, the patient who comes to see them must be able to believe that person will do everything reasonable and necessary to ensure their well-being in the long run.

To that end, the Bureau of Prisons must shift the chain of command for physicians and health care providers as a whole so they do not, as Mr. Quinlan and Dr. Moritsugu said, report on a daily basis to superiors, such as wardens and associate wardens, who are not medical staff, so that they report directly to the assistant director, health services division, medical director, a position always filled by a physician.

As the corollary to that, it's really important for the medical director to have authority to go along with the responsibility. By authority, really it boils down to money and positions, as almost all things in government do. The Health Services Division of the Bureau of Prisons must have its own budget, which includes those of each health services department in all institutions; and it must be responsible for the allocation of new positions directly to health services departments in all institutions. Without that, there can never be any assurance that health care services will be appropriately staffed or appropriately funded, because right now the system allows those resources to pass through the regional office and then the executive board of each institution where there is no representation of medical issues by medical professionals. Thus, the intentions of the central office are frequently diluted or completely eliminated.

Another problem that keeps health care providers from being fully functional is that they don't often have adequate access to supplies or equipment. This is most commonly due to the fact that administrators within these departments are people who are promoted up through the ranks simply by matter of seniority or performance, but not because they're adequately trained for the job. They are not trained for health services administration.

The Bureau must implement mandatory training of those individuals who are already in such positions or anyone applying for these positions. That training should not only come from within the Bureau of Prisons, but from many well-established external programs as well.

There is one other aspect of the adequacy of supplies and equipment. Despite what the Bureau of Prisons says, my experience, even up to the last day I worked at Los Angeles, was that medical records for inmates, even those transferred within the Bureau of

Prisons, but certainly for those coming from anywhere outside the system, were not regularly available. That really hampers the ability, especially of physicians, but all health care providers as well, to function effectively.

One additional part of this plan to enhance the image of physicians as fully functioning professionals is that the Bureau must concentrate more of its effort in providing clerical support. As an example, in the time I worked in Los Angeles I typed every single one of the reports I submitted, at a cost to the Government of more than \$40 an hour. I did this for many, many hours nearly every day.

At all levels, the most important factor is that health care delivery needs to be planned, coordinated, and supervised solely by physicians. Right now each department at each institution has two heads, and they share equal authority over allegedly separate areas, but it's basically all one and the same thing. The administrators are peers of the physicians; they are each other's equal. Unfortunately, because of problems with the training of administrators and because they often feel insecure, much energy is spent in argument rather than collaboration. The Bureau must make health services administrators subordinate to the chiefs of health programs at each facility.

For all of these aspects to function successfully, it's imperative—and this is just a re-emphasizing of what other people have said today—that there be mechanisms to assure that medical staff are both competent and dedicated, and, if possible, to assess the fact that they have compassion for the people for whom they care. There are a variety of examples I could cite of things I saw within the Bureau of Prisons, particularly at Springfield, that exemplify how this happens, but in listening to the testimony given by the inmates today, I found that it evoked in me a very strong recall that there is a tremendous amount of suffering on the part of individuals, on the part of people who are really human beings—even though they are incarcerated, they are still human beings—that really goes unfelt by a lot of the providers who deal with them, and certainly goes unexperienced by people who are not the next-of-kin or closely related to these individuals, nor by people who do not find themselves in the same setting.

As I say, I have many examples I could cite, but I do not wish to dilute what the inmates themselves have said. I emphasize that that sentiment, if not specifically that testimony, be borne in mind by the committee in dealing with these issues in the future.

Lack of compassion is one of the mechanisms by which care is commonly denied. I think it's really a gross violation of individuals' civil rights. Under certain circumstances, certain physicians, whose activities are acknowledged but not controlled, force inmates into situations where they are so frustrated by the delivery of care that an argument ensues, and subsequent to this they are labeled as being uncooperative or belligerent. As a consequence, further care to them is denied, often for an indefinite period.

In order to ensure that the Bureau employs the most competent individuals, it's imperative that health care workers be hired by physicians, or at least that the decision to deny hiring be made by a physician. This is not consistently the case even at this date.

Even though the central office has policies in reference to this, they are not regularly followed at the institutional level.

It's also important that the Bureau mandate a minimum level of competence for health care providers. One specific aspect of this minimum standard should be that all will be certified in advanced cardiac life support, which is also known as ACLS, and which is the kind of care anyone in this room might receive if they had a sudden event leading to the arrival of emergency medical personnel. Obviously, outside ambulances do not readily get into prisons, so it is important that the people who respond be able to do so effectively, and that often is not the case.

Another reason why review mechanisms might be helpful is that right now the way the Bureau reacts to possible failures is often very arbitrary in initiating reviews and also very arbitrary, or at least seemingly arbitrary, in taking actions against health care workers who have not lived up to the standard that the Bureau sets.

One last reason to do this is that right now health care workers—and I don't think anybody has emphasized this before, but this is really important—health care workers in corrections, because of the high influx of individuals with communicable diseases, and the one that I think of the most is not HIV but actually tuberculosis, are at significant risk of contracting serious diseases, some of them potentially fatal, in the course of their work. I don't think anybody should be subjected to this kind of risk in the workplace.

One of the points made by the Bureau of Prisons regarding their attempts to recruit additional staff is that there should be a mechanism for providing higher salaries to physician candidates and possibly to physician assistant candidates. That's absolutely not going to be an answer to the problem. I don't think the Government could ever compete with what physicians make in the private sector, and it overlooks the fact that many people come into the Bureau of Prisons as health care workers, and particularly as physicians, for very good reasons, and money is really not one of them.

The committee might consider the possibility that individuals have shorter years of service. At the end of such a period of service, there may be special and significant benefits awarded to voluntary participants. That would certainly eliminate the problem of burn-out, which after several years is likely to happen to people who work in this highly adversarial environment.

The Public Health Service might consider making tours of duty through Bureau of Prisons facilities, and possibly through correctional facilities at other levels, mandatory for its staff.

In addition, I strongly support consideration of establishing something akin to National Health Service Corps scholarships, but making them specific for Bureau of Prisons, or at least correctional, service, in a manner analogous to how the Indian Health Service currently sets up its scholarship programs.

Finally—and this reflects directly on the comment made today by Director Quinlan and Dr. Moritsugu—it's imperative that people coming into health care in corrections receive appropriate training. In my experience, what is offered at the Federal Law Enforcement Training Center in Glynco, GA, is fine for correctional purposes, but it hardly helps in getting ready for health care delivery in a

correctional setting. The Bureau has frequently talked about, but never implemented, a special training program for health care providers. That really needs to be done.

Once a person has been trained and is put into the field, they need to have good references as to how they should function. That reference in the Bureau of Prisons is the Health Services Manual. It really needs revision. It is way too long; it is hardly accurate.

There are other aspects about care that inmates receive that warrant more broad-based discussion, and some of them have already been raised. I would like to emphasize the fact that public health issues for the community can be addressed in a correctional setting. In the Metropolitan Detention Center in Los Angeles, we had 30,000 admissions in the last calendar year. Of those people, we updated vaccinations in 15,000 adults in 1 year, most of whom went back into the community in Los Angeles. We performed complete physical examinations on over 5,000 of those individuals. Most of those people had had previous contact with the health care system, but not in a manner that made them up to date with preventive health care measures, and many of them had never previously seen a physician or a dentist at all.

There are also issues regarding the right to minimum levels of care, which are quite well defined within the Bureau of Prisons, whose discussion in an open forum would benefit society as a whole, given the fact that there are so many people who lack health insurance in this country.

I could go on—the list is rather lengthy—but I will defer to questions and answers. Thank you very much.

Mr. HUGHES. Thank you, Doctor.

[The prepared statement of Dr. Landucci follows:]

**SUBCOMMITTEE ON INTELLECTUAL PROPERTY AND JUDICIAL ADMINISTRATION
HOUSE COMMITTEE ON THE JUDICIARY**

**OVERSIGHT HEARING
MEDICAL CARE IN THE FEDERAL PRISON**

**WRITTEN TESTIMONY OF DANTE LANDUCCI, MD
FORMER MEDICAL OFFICER, U.S. MEDICAL CENTER FOR FEDERAL PRISONERS,
SPRINGFIELD, MISSOURI
FORMER CHIEF OF HEALTH PROGRAMS, METROPOLITAN DETENTION CENTER,
LOS ANGELES, CALIFORNIA**

SUMMARY

To improve inmate health care, the mechanisms for its delivery must be made as similar to those present in the community as possible. In order for the Bureau of Prisons (BOP) to accomplish this, three areas require improvement: 1) establishing and maintaining a non-adversarial relationship between patient and provider; 2) supervision of health care delivery by physicians; and 3) implementation of medical quality assurance. An additional benefit of the proposed changes would be increased cost-efficiency in providing health care to this population.

THE PATIENT-PROVIDER RELATIONSHIP

Factors impeding the development of an optimal relationship include the following.

Individuals predisposed to significant criminal activity have a psychological profile which incorporates inherent distrust of strangers. For such people, relationships of all sorts are difficult to establish.

Inmates commonly attempt to compensate for loss of freedoms by manifesting a sense of entitlement to the delivery of all aspects of medical care. They overlook the fact that resources are allocated on the basis of need rather than demand.

Many prisoners have had little or no exposure to medical services prior to incarceration. Their resultant lack of sophistication often leads to the development of unrealistic expectations.

Correctional medicine requires providers to limit access to items normally not so controlled in the community. The easiest and most prevalent example is the dispensing of shoes other than those of standard issue to inmates. In many facilities, whether an inmate may wear sneakers is a decision made by a health care provider. Such unusual circumstances may have good underlying reasons for their existence, but still increase the level of friction.

Another unusual aspect of correctional medicine is the level to which it is regulated by

legal concerns. Providers are mandated to deliver varying levels of care, even if the patient refuses, further intensifying conflict and distrust.

Inevitably, staff will find the prison environment filled with adversity, high pressure, and heavy demands. Collectively, these lead to comparatively early "burn-out" of providers, making them, too, unable to relate properly to patients.

Finally, no level of patient confidence can be expected to evolve if health care providers are not sufficiently competent to deserve it.

The following are proposed solutions to these problems.

Policies mandating that health care providers must act as correctional officers first and foremost must be abolished. All employees must be constantly vigilant, but health care providers should be regarded as independent professionals.

The standard of performance expected of each type of provider and in commonly encountered situations needs to be stated explicitly and concisely. This information must be widely distributed in an accessible format designed to make it easy to assess whether an individual's performance meets the level of expectation. Updates regarding changes in policy, public health concerns, court rulings, legislation, etc., must be provided on a regular basis. The Health Services Manual, the reference guide currently used by physicians in the field, does not meet these needs and should be revised.

The instructional material used at the Federal Law Enforcement Training Center is only partly relevant to the needs of Medical Officers and other providers. A separate course, including this pertinent material but focusing on the special aspects of health care delivery in the correctional setting, is necessary. At annual gatherings of Chiefs of Health Programs this has been identified as a matter of exceptional importance. Yet, no action has been taken by Central Office staff.

Also needed are mechanisms by which inmate access to the medical system can be limited only to the extent necessary to prevent over-utilization. Abuse of health care resources by some inmates leads to diminished quality of care to others, and increases cost. It also enhances the potential for an adversarial perspective to develop on the part of providers. On the other hand, education must be provided to inmates explaining what services can be reasonably expected and how to best gain access to them.

The Bureau needs to be afforded whatever resources necessary to provide creative incentives to attract medical personnel. Higher salaries alone are not enough. In fact, increases in monetary compensation seem only to have attracted more individuals who are, at best, marginal in their abilities. This is probably because the earning potential of competent physicians is far greater in the private sector than government can ever hope to match. Truly qualified candidates whom I have interviewed were looking for other sorts of returns. Some of these could be met by limiting the duration of tours of duty. Other alternatives include facilitating transfer into other government agencies. Combining this with a program of mandatory tours of duty for Commissioned Corps personnel might benefit both the BOP and the Public Health Service, which face similar recruitment problems. Likewise, progressive arrangements with the Department of Veterans Affairs could also prove mutually beneficial.

Another way to enhance recruitment would be to implement a scholarship program with a service obligation. While the experience with the National Health Service Corps Scholarship Program has been less than optimal, there is a simple way for the BOP to avoid the same problems. Limiting the scope of the program, as has been done by the Indian Health Service and, to a greater extent, the Department of Defense, would lead to a greater rate of successful completion of obligations. By its own projections, the BOP requires less than 200 full time Medical Officers. Careful rotation of awards should make it possible to fill a significant portion of these positions with scholars serving for two to four years.

The hiring of practitioners through a such scholarship program would attract providers recently out of training. While they may lack experience, they would introduce a high level of expertise reflecting the latest developments in medical practice.

All hiring of health care staff should be under the control of a physician. Contrary to existing policy to this effect, this is still not always the practice within the Bureau.

THE ADMINISTRATION OF CORRECTIONAL MEDICAL SERVICES

Administrative factors adversely affecting the performance of health care providers include the following.

Health Services Administrators (HSAs) are not required to have training specific to the field of health care administration. Presently, positions are almost exclusively filled by individuals who have experience only as Physician Assistants, often gained strictly within the BOP.

HSAs are not required to demonstrate competence in ordinary bookkeeping, accounting, nor comptrollership. Despite this, they are given oversight of budgets of hundreds of thousands of dollars.

HSAs are given a level of responsibility exactly equal to that of the Chief of Health Programs (CHP), the highest ranking physician in an institution. By granting them exclusive supervisory authority over the majority of department staff, and because they unilaterally control the expenditure of funds, HSAs often impede medical decisions solely on administrative grounds.

Health care personnel are subordinate to Associate Wardens and Wardens, who are never medical personnel. Therefore, conflicts between HSAs and Medical Officers are arbitrated by individuals who have less than a thorough understanding of the issues involved. Because physicians do not rise through the ranks, and receive salaries which are higher than those of their supervisors, there is often resentment and bias against them.

The budget and staffing of Health Services Departments at all institutions are determined by the Warden and Associate Wardens. Despite an established standard for staffing based on the workload, most departments function with significant personnel shortages. While this sometimes reflects an inability to recruit adequate candidates, more often it is due to an administrative failure to designate the proscribed number of positions.

Due to inadequate staffing patterns, providers, including physicians, are expected to do at

least some of their own clerical tasks, such as typing and locating or filing medical records.

The following are proposed solutions to these problems.

Training in all facets of health care administration and small business finance and management should be mandatory for all applicants and HSAs. The problem is so severe that it must be addressed as an immediate priority. Furthermore, the Bureau must look outside its own instructional resources. There are numerous private programs in these areas which exceed what can be provided by the BOP.

Effective health care delivery results from having its planning, coordination, and supervision controlled by a physician. Optimal productivity cannot be achieved when staff work for two supervisors. Therefore, HSAs, and all other department staff, must be subordinate to the Chiefs of Health Programs. This type of structure has been repeatedly shown to be effective in other settings.

The CHP should be directly subordinate to the Assistant Director, Health Services Division (Medical Director), a position which is always filled by a physician.

The Medical Director must have control of the distribution of funds and positions to the Health Services Department at all institutions.

More attention must be given to hiring clerical support staff, despite the long-standing resistance to this change by Wardens and Associate Wardens.

MEDICAL QUALITY ASSURANCE

The arguments favoring Medical Quality Assurance (MQA) are probably well known. Still, some aspects of these practices deserve emphasis, as they relate specifically to improving correctional health care delivery.

Current reviews, as conducted by the American Correctional Association and the Bureau itself, do not focus on the health care of the individual. Areas that are examined relate to the needs of groups, such as female inmates, and overall safety of individuals, including staff, who enter the department. While credentials are reviewed to insure they are legitimate and up-to-date, providers are not regularly assessed with regard to competence, training, or past practices.

When individual review has occurred, it has often been prompted by catastrophe, rather than served as a preventive measure. Furthermore, actions which have been taken often appear arbitrary and harsh. As a consequence, staff have developed a fear of MQA.

Without MQA, the Bureau can never be sure of what level of health care is being provided. As an example, data have been collected on the rate of HIV seropositivity among inmates. Yet, there is no knowledge of how accurate the contract laboratory is; errors in testing have only been found incidentally. This data has been represented as accurate to oversight and public health agencies, such as Congress and the Centers for Disease Control, while internally it has been acknowledged that the reporting error may be as great as 300%.

On the individual level, such errors cause care to be misdirected. There are also significant monetary costs incurred in settling the resultant personal injury claims. On a broader scale, misdirected policies and legislation may be the result.

CONCLUSIONS

Based on my experience, it seems reasonable to conclude that, for the vast majority of inmates, the Bureau of Prisons provides adequate medical care. Unfortunately, there are no adequate data on which to base this judgement. More important, when failures occur, they tend to be catastrophic. These events occur despite the very good intentions of both Central Office and institutional staff.

An additional, substantial factor which impedes better performance, is the scope of problems inherited by the current administration. Prior to the appointment of J. Michael Quinlan and Dr. Kenneth Moritsugu, little attention was paid to practicing medicine within BOP facilities at a standard equivalent to what was available in the community. The competence of health services personnel was not considered important. Thus, the Bureau trained many of its own Physician Assistants without regard to competence nor outcome. HSAs have not been at all prepared for their roles. Physicians who sought haven from their own acts of malpractice in the private sector seem to have been hired regularly without any awareness of their past actions.

While many of the corrupt Medical Officers have been weeded out, most of this old guard of HSAs remains. This fact alone should give greater strength to the need to restructure the hierarchy of health services staff as proposed above. But it bears emphasizing that much of the Bureau is still a "good ol' boy" organization. If newly recruited physicians, who are often viewed with suspicion as outsiders, are to be at all effective in administering medical care, they must be allowed to practice in accordance with professionally accepted standards.

In this regard, special attention needs to be focused on the U.S. Medical Center for Federal Prisoners in Springfield, Missouri. In this enclave, free from serious professional scrutiny, physicians have been able to construct and maintain an environment designed for their own comfort; patient care has been a secondary concern.

There have been some improvements in the situation at Springfield, due in part to the recent turn-over in physician staff. These changes have also been the result of the actions of Central Office staff and non-medical administration of the facility, and the persistent good will and professional demeanor of the rest of the health care providers. However, I remain convinced that much more needs to be done. Increasing the level of outside scrutiny, including intervention by this Subcommittee, would expedite change at the Springfield facility.

There is widespread utility for certain aspects of health care practices as implemented within the Bureau.

Its policies mandate regular attention to public health measures, based on the established great benefits of prophylaxis and prevention. Specific areas where the community

significantly benefits from money spent on the health care of detainees include:

- education about and screening for AIDS and sexually transmitted diseases;
- education about and rehabilitation for substance abuse;
- first time immunization against childhood diseases, administering adult boosters and vaccines against annual epidemic infections such as Influenza.

Due to supervision by the courts on the issues of civil and human rights, concepts regarding consent for treatment are far more developed within correctional settings than is generally the case in the private sector. This is especially true of matters relating to mental health care.

In studying the concerns of society, Congress cannot overlook that the BOP has the fastest growing budget of any government agency. Of this, the Health Services Division is the fastest growing part. Thus, the cost per capita of health care delivery to inmates is increasing extremely rapidly. There should be discussion as to when the burden may exceed the benefit. When does society gain less than it pays for incarceration of individuals, especially given the inability of so many free Americans to have assured access to medical care?

In this vein, is society really reaping the purported benefits of jailing such a large portion of its population? Many claims are made, but the objective data does not support the fact that aggressive criminal prosecution and punishment has made our streets any safer. Even if there had been an improvement, what has been the cost per unit? Are there less expensive ways of attaining the same result? There is a growing sense that our current course of action may actually be making the situation worse.

Mr. HUGHES. Dr. Landucci, you spent almost 3 years at Springfield?

Dr. LANDUCCI. Yes, I did.

Mr. HUGHES. OK. There's been a lot of criticism of the medical staff at Springfield. I wonder if you can give us your observations on the caliber of the staff insofar as licensed, unlicensed, competent, not so competent, caring, not so caring? And you can be as specific as you want to be.

Dr. LANDUCCI. I would like to offer clarification regarding a comment made. Licensure requirements for physicians in the Bureau of Prisons, as far as I know, are now uniform. The absence of a requirement that physicians be licensed by the State in which they are practicing does not mean that those individuals are exempt from meeting the requirements of the State that issues their license. For example, I have practiced with the Federal Government for years and am licensed solely in California and Utah, but I worked in Springfield, MO. I was required to meet all the licensure requirements that California and Utah had when I renewed my license.

With regard to Springfield, I think that the most accurate thing to say about that facility is that it represents a specifically greater level of problems than health care delivery anywhere else in the Bureau of Prisons, as far as I can detect. I have been in Rochester on a few occasions for relatively short visits, that were related to delivering patients who required acute medical or psychiatric intervention. I have a good sense of how that facility works. I've had the opportunity to see many patients who come to me from Butner, Ft. Worth, and Terminal Island. In reviewing their medical records, I have found no evidence of any greater level of problems than are encountered elsewhere in the Bureau of Prisons. But, I would say that, certainly from my experience, and probably continuing to the present, Springfield represents a much greater problem in health care delivery than any place else in the Bureau.

My—

Mr. HUGHES. Why is that?

Dr. LANDUCCI. It was attested to earlier by the inmates. It really relates to the fact that the physician staff at Springfield is hardly progressive. They have fought tooth and claw to prevent the introduction of medical quality assurance, the introduction of cost containment measures. They have attempted to set themselves up in an environment in which they can deliver health care in the most comfortable manner to them.

When I first arrived at Springfield and I was interviewing for the position there, I was taken on rounds by one of the internists working there. We walked into a ward where there must have been at least 12 patients, maybe 15, maybe even 20, and we did not stay in that room 10 minutes. Yet, that constituted daily rounds for each of those individuals.

Not one of the patients was examined. I don't think that any of the patients was even interviewed sufficiently to obtain any significant medical information about them. The whole idea was to enter and leave as quickly as possible, to entertain as few medical issues as possible.

Mr. HUGHES. That was on your first round?

Dr. LANDUCCI. That was the very first time I went there.

Mr. HUGHES. And, was that your experience throughout your stay?

Dr. LANDUCCI. Consistently, I would have to say that some of the physicians performed at that level. I would say, in addition, one of the physicians on staff refused to admit patients who had significant levels of illness because he wanted to keep his census down and also he wanted to avoid having to work excessively hard.

Other manifestations of this, I was once surprised—I knew this was happening, but I was once surprised to have it, frankly, admitted to me—that patients at Springfield were not discharged in a timely manner in an attempt to prevent incoming admissions from arriving from other parts of the Bureau, thereby controlling the level of work.

And, this was at a time when the level of health care in the Bureau was increasing quite rapidly because of an influx of greater numbers of patients and, among those patients, more and more of them had serious diseases.

Mr. HUGHES. Was that the practice and procedure generally or were they isolated cases involving specific practitioners?

Dr. LANDUCCI. I would have to say that it involved specific practitioners. I think that the impression conveyed by at least some of the inmates who testified was that practitioners who were relatively recently out of medical training, specifically the people that I worked with who were National Health Service Corps obligated scholars, continued to perform at a quite high level of expertise. Most of these people were receptive to the introduction of medical quality assurance issues. Most of these people worked very, very diligently.

Another case in point where you can get a feeling for the disparity in the level of care. The institution at Springfield I believe still has this policy; I'm not sure. But, at least when I was there, the call for the entire institution would be taken by one individual, one individual physician, each night—not a big problem because a lot of the patients there really are there for chronic care purposes. But, they would have psychiatrists covering surgical and medical patients or surgeons covering psychiatric patients. There's a problem there because people are really crossing over into areas of expertise which are significantly different.

Mr. HUGHES. Who approved that? I mean, that has to be approved by the director of the medical facilities?

Dr. LANDUCCI. It was approved by the chief of health programs at that facility.

Mr. HUGHES. How can you have that practice and procedure in a facility such as Springfield and not have those responsible for the operation of the facility not aware of it?

Dr. LANDUCCI. I think, not to cast an indictment against the people who operate the facility—and, by that, I assume you mean the warden and the associate warden—I think that they were, in fact, aware that there might be a problem with this practice, but they—

Mr. HUGHES. No, no, not necessarily the warden, not necessarily the warden and the associate warden, but those responsible for operating the medical facility, the director of the facility, for instance.

Dr. LANDUCCI. But, this was the policy of the person responsible for directing the medical facility.

Mr. HUGHES. I see.

Dr. LANDUCCI. That's the chief of health programs. That's the highest ranking physician at the institution.

Mr. HUGHES. I see. So, the policy was set by the director of the facility?

Dr. LANDUCCI. Absolutely. And, just to finish, so you'll understand what level of difference there was between the care provided by, say, the career medical officers and the transient, younger staff in the National Health Service Corps. After a very short period of time the National Health Service Corps people set up their own call schedule and would cover their patients on a much more frequent basis, simply because they wanted to make sure that their patients received appropriate care.

The reason why the medical staff chose to have people cross-cover in radically different areas of specialization was really because it made the call occur far less frequently.

Mr. HUGHES. I asked some questions today of the Director about the line of command, whether or not there was a semiautonomous administration in the medical facilities. The answer was that, while there may not be a day-to-day accountability, that headquarters, Washington, has frequent contact. Was that your experience or were you in a position that you would know?

Dr. LANDUCCI. Yes, I'm in a position where I would know. As chief of health programs in Los Angeles, I frequently found myself in situations where there were potential conflicts of interest between what medical staff wanted to do and correctional staff wished to do. I would say that Ken Moritsugu's office, the Health Services Division central office, functions primarily as a source, a reference source for medical staff; that is, to call them to get information. But, you can rarely count on being able to call them and get resolution of a problem.

The reason for it is that the office has comparatively little authority for the level of responsibility assigned to it. The decisions almost invariably were resolved by wardens at the local level. That, again, goes back to the issue that it's not appropriate to have nonmedical staff ultimately making medical decisions, even though they may claim to assume responsibility for doing so. It's just not appropriate. You cannot guarantee that you will deliver an appropriate level of care to patients consistently.

Mr. HUGHES. I wonder, just moving to you, Dr. Thorburn and Dr. Greifinger, if you can tell me how the State system differs to what has been described as the practices in the Federal system? Let's start with the last question: how much autonomy is there in the medical divisions of the State prison system in Hawaii?

Dr. THORBURN. OK. I think there are probably 50 different systems in the State systems.

Mr. HUGHES. Let's talk about Hawaii.

Dr. THORBURN. In Hawaii, health care workers report to me, as the medical director. I'm very fortunate in that I have a supportive director of the department of public safety with whom I work who understands that he doesn't possess great expertise in provision of health services and understands that it's important to defer to

somebody who does have some knowledge in this area. Therefore, he has insisted that—we're actually in the process of reorganizing our services now so that it's very clear that I have a direct line of authority over all health care staff. There's ready access to me. I'm the person who makes the final health care decisions. I'm the one who takes on the wardens if there is a conflict; that doesn't have to be left to line staff.

In addition, the major part of the reorganization that's occurring right now is I have taken over complete control of the health services budget. Before the reorganization, we'd find that, if there was an overrun, for example, on guard overtime costs, very often they'd dip into the health care budget to pay those excesses. So, that's no longer going to be possible because all of that money is going to be in my office.

Mr. HUGHES. How familiar are you with the operation of the Federal system?

Dr. THORBURN. I'm not too familiar with it.

Mr. HUGHES. OK. What kind of care does Hawaii provide for its inmate population?

Dr. THORBURN. We provide community-centered care for inmate population.

Mr. HUGHES. What does that mean to a layman?

Dr. THORBURN. Our inmates have access to pretty much what they would have in the community. We work very closely with our health department to develop public health programs. We do a lot of screening. We do regular vaccination campaigns for preventive health. The level of dental services that our inmates get is extremely good. Dental health is a major need.

Mr. HUGHES. Do you have problems recruiting health care—

Dr. THORBURN. Recruitment is a constant function that I undertake.

Mr. HUGHES. Do you have vacancies in your system?

Dr. THORBURN. Yes.

Mr. HUGHES. What percentage of vacancies?

Dr. THORBURN. We're running at about a 10-percent vacancy—

Mr. HUGHES. How about you, Dr. Greifinger?

Dr. GREIFINGER. Twenty.

Mr. HUGHES. About 20 percent? Do you have a problem also recruiting?

Dr. GREIFINGER. Yes, we do.

Mr. HUGHES. For all the same reasons the Federal Bureau of Prisons has problems recruiting, I presume?

Dr. GREIFINGER. Yes.

Mr. HUGHES. What do you pay, let's say, an orthopedic surgeon?

Dr. GREIFINGER. New York State has one title called physician II, and the range for that runs between \$78,000 and \$93,000 a year.

Mr. HUGHES. Not very much, is it?

How about you, Doctor? What do you pay in Hawaii?

Dr. THORBURN. Our pay is terrible, and I've had to do a lot of creative schemes to bring it up to some level where it's comparable to the community. Our physician II, the established printed salary is about \$50,000 a year. With some creative schemes, I've gotten

that up to \$72,000 a year, and that hardly meets the cost of living in Hawaii.

Mr. HUGHES. Not very much, is it, in that tough environment?

You may have heard—in fact, I think that one of you on the panel alluded to a pilot program to deal with the inappropriate use of medical care. What comments do you have about that? Ms. Alexander.

Ms. ALEXANDER. I think this is, for all the reasons that the committee has heard today, perhaps one of the most critical issues that the Bureau of Prisons needs to address immediately. It has not had a system in place to assure that prisoners routinely receive a basic level of care.

I believe that the doctors on the panel would be far better able to address the specifics of how such a care system would work.

Mr. HUGHES. But, you can see there's a problem?

Ms. ALEXANDER. Yes.

Mr. HUGHES. There's a problem. It must be very difficult not to get burned out. You have to work at it constantly. I think the suggestion of peer conversation and consultation among caseworkers and health care providers discussing particular problem cases, is a good suggestion. However, it's a problem. How do you deal with that? I mean, how do you deal with a problem where 10 percent, 10 to 15 percent, of the prison population on a given day is seeking care—for the reasons that they want to get out of work, because they want someone to talk to?

You probably could argue that many of them have psychological/psychiatric problems, and that's the reason in some instances they're seeking that medical care, but there is, unquestionably, a major problem in dealing with people that don't really need attention but who are coming or asking for another consultation after being there the previous day or the previous week.

Ms. ALEXANDER. Mr. Chairman, if I could point out several things that perhaps are some points that could be made in response to that: first, I think Dr. Landucci's suggestion that the way to work on the vacancies is by expanding the public health scholars programs and things of that nature, that's a wonderful suggestion and I think it's fully appropriate.

Mr. HUGHES. That's an excellent suggestion, but it doesn't get at the root problem. That will assist us perhaps in identifying additional health care professionals—

Ms. ALEXANDER. Yes.

Mr. HUGHES [continuing]. For the system. Part of it is probably the system strain, because we don't have enough physicians actually operating within the system. But, dealing with the problem of malingering is a different problem.

Ms. ALEXANDER. I think to look at it as malingering is to see the problem in a light that doesn't reflect all of its aspects. When prisoners in a system feel that there is a system in place that responds to their needs, then they're not going to keep showing up. One of the things that may be reflected in the statistics that the Bureau is reporting is the prisoner who goes in today and doesn't have an appropriate response to his or her complaint and, therefore, comes back tomorrow and the next day and the next day, because there's

never been the sort of review of what the prisoner is saying that needs to be done.

If there is a system in place that reaches out to give appropriate health care, then that level of attempts to get access to the system is not going to occur. What you're seeing in this rate is in part a symptom of what's wrong with the organization of the Bureau of Prisons health care.

On a somewhat related point, I'd also like to suggest that the problem is prisoners' perception that they don't have community-level care, and that is a very deeply rooted perception of prisoners in the Bureau of Prisons. To the extent that the Bureau relies on what truly is community health care, relies on care in the community, those perceptions will be addressed. I think it also would be an economical way for the Bureau to provide health care, and it would provide better health care.

Mr. HUGHES. Let me just break right there because that's a vote that I'm going to have to run to catch. We're going to recess for about 10 minutes.

[Recess.]

Mr. HUGHES. The subcommittee will come to order.

Ms. Alexander, I'm a little bit confused about something. If I understand you correctly, you're suggesting that because the health care facilities are not responding to the inmates, that that encourages them to continue to look for other ways to get care? Did I hear that correctly?

Ms. ALEXANDER. Well, if I could try to clarify a bit. One thing that might be inflating the statistics that the Bureau was reporting is that if Joe Smith signs up on Monday and requests that something be done about his cough and nothing happens and he isn't examined or diagnosed, it seems more likely one of the things that could happen is that Joe Smith could show up on Tuesday, on Wednesday, on Thursday, and so forth, because Joe Smith is still concerned about his cough.

Mr. HUGHES. Do you have anything to support that or is that just a speculation on your part?

Ms. ALEXANDER. I think it's based on my experience in this field. I don't know how one would design something to test that statistically.

I think the other thing that I would suggest—and I'm certain that Dr. Thorburn could address this much more systematically than I could—is that if you have a health system that's appropriately set up to reach out and meet the health needs of the prisoners, you're not going to see that level of prisoners showing up to sick call. I think that Dr. Thorburn could—

Mr. HUGHES. Well, maybe you can help us with that. I suppose you see the same thing in the State system. You have a certain amount of inmates faking their symptoms, for one reason or another, to gain access to the infirmary or the medical care facility.

Dr. THORBURN. Our system is used more than—I mean, this population in our system uses health services more than they are using them in the community. I don't characterize it as overuse.

I'd also like to emphasize that this usage is not due the majority of the times to malingerers. Malignerers are far and away the minority of patients whom we see. Yes, we have malingerers who ma-

nipulate the system. That's often the characterization of the over-use. I mean, that's very often what's thought of prisoner patients, is that they're malingerers, but it's rare that we see true malinger-ing going on.

If we need to give it a behavioral characterization, it's perhaps hypochondria, but I think it's more a fear that they're not going to get the care that they need and it's a testing of the system. I think that the requirement is to change the system so that they know they can access the system when they need it.

I saw in Hawaii—I've been there for 4 years. When I arrived, we had a system with tremendous barriers to services; that is, all the health professionals sat in the medical unit, weren't ever out among the population, and it was very hard for the population to get to the medical unit for care. The demands on the system were tremendous.

I went in and I sat down with the staff and I said, "You guys are going to get out among the inmates. We're going to go out and we're going to deliver some of the services out there. You're going to be visible. And, what's going to happen, there are going to be a lot more demands at first and then you're going to see the usage go down," and that's, in fact, what happened in our system. Once the health professionals were out there visible and accessible, the usage rates actually went down.

I also think that the point was made that we have to approach our patients with compassion, understand that if somebody is coming to us complaining, it's because they are in anguish; they are suffering. We have to try to understand. It may not be something physical that I can see objectively. I'm an internist, so I look for physical illness, but I have to understand that they're coming to me because there is some suffering. I have to deal with that suffering in order for the patient to go away satisfied and not to come back again.

MR. HUGHES. Dr. Greifinger.

DR. GREIFINGER. Mr. Chairman, I believe there are several issues that need to be considered when one counts the way we heard counting. In New York, likewise, we have many visits. We have an average of 33 visits per inmate per year. But, the counting needs to be considered in context.

If you or I go to our medicine cabinet for an aspirin or an antacid, we don't need to consult a nurse; an inmate does. That counts as a visit. Likewise, if we go see our physician and the physician sends us to the laboratory the next day for some tests, it counts as one physician visit. But, an inmate will see the physician, come back the next day to have blood drawn, and that counts as two visits. So, it's really a matter of counting which inflates the numbers.

Second, the matter of insecurity and testing that Dr. Thorburn mentions—and I think that's very important, and that's one area where I believe we can do a lot with attention to prevention and primary care and building an ambience which is as therapeutic as can be in an adversarial system.

Third, and something I believe is very important, is that correctional authorities have medicalized problems which are not medical problems. If an inmate finds himself uncomfortable in the shoes that he's wearing, they say, well, go to the doctor. The doctor then

has to prescribe sneakers. Or, if an inmate has dry skin and the inmate wants skin creams or showers more frequently than might be allotted in a facility that is antiquated and might offer showers, let's say, two times a week, and the inmate wants to take more showers, the answer is, well, go to the doctor, only if the doctor prescribes it. Clippers for beards, certainly inmates get in-grown hairs and find if they use razors, the standard issue razor, it's inflammatory to their skin, and they'd like permission to use clippers. That's something that's medicalized that wouldn't normally be medicalized outside.

Mr. HUGHES. Well, that's very helpful. I hadn't thought of that particular perspective as far as how you count and the need to go to a physician for a whole host of things that ordinarily you would just do automatically in your own household.

Let me ask you, Ms. Alexander—much of your testimony was directed to the Springfield, MO, facility. Do I take it that you believe that most of the problems you've seen are at the Springfield facility?

Ms. ALEXANDER. Mr. Chairman, I think one would have to add to that very specifically the problems with the transport system and the delivery of medication.

Mr. HUGHES. Just talking about facilities, not the transportation.

Ms. ALEXANDER. All right. I am not in a position to differ with Dr. Landucci. I don't know a great deal about the facilities other than Springfield, but what I know about Springfield is certainly consistent with what Dr. Landucci said.

Mr. HUGHES. Well, Dr. Landucci, he can speak for himself, but I think he would suggest—and you can answer—that the facility in LA, where he worked for several years, was a fine facility. They rendered good care. Am I correct, Doctor?

Dr. LANDUCCI. Yes.

Mr. HUGHES. Of course, he was the chief medical programmer there.

[Laughter.]

Ms. ALEXANDER. I have no reason to disagree with that testimony.

Mr. HUGHES. My perception is that the overall care at the Federal facilities is fairly good, and I've been to a number of facilities and I continue to go to new facilities. I look at the medical care, in addition to other things, at these facilities.

It seems to me that we've identified some problem areas that we need to examine more closely, but they fall into a number of different categories. The States have the same problem in recruiting. That's a major problem.

The cost problem is out of hand because we're having to contract out more and more services. Delays in treatment might be attributed to a number of reasons. A significant factor might be that resources are strained at facilities like Springfield. They have one psychiatrist when they need seven, for instance, or they have two in place but five vacancies.

The psychiatric and psychological problems are serious in all the systems. So, when you're short five psychiatrists, it's got to put a strain on those who you have left. It doesn't take long for burnout

to occur for those who are left. That might account for some of the problems that we've experienced. I'm not excusing it.

Some of the problems that we've seen is attempting to get to patients. One of the complaints I heard over and over again from the inmates and from others, anecdotal in nature, is that it takes too long for medical staff to get to a problem, and then the problem become more acute, more costly, more serious. But, again, part of that perhaps is because of strained resources resulting in not enough health care providers rendering the service. As a result, attempts are made to find others that are not qualified to provide many of the services.

Ms. ALEXANDER. Mr. Chairman, I would suggest that perhaps one appropriate response that the Bureau did not take at Springfield with regard to the psychiatric program that it should have taken is that if it can't staff, which apparently it can't, over a prolonged period an adequate psychiatric program, it should be placing its psychiatric patients in the community.

There's no excuse for the level of vacancies that's existed for some time at Springfield. Director Quinlan has a marvelous reputation in the field of corrections and I have great respect for him as a professional, but health care is simply not an area in which the Bureau of Prisons has its normal reputation. This is a serious problem area. We've just scratched the surface on the level of concerns that exist about that system.

Mr. HUGHES. Let me take you back, if I might, Dr. Landucci, to Springfield for just a minute. Who is actually making the decisions there insofar as the day-to-day operation of that facility, or when you were there who was making those decisions?

Dr. LANDUCCI. In general, those decisions are made—well, there's really not an organized way by which they're made. I mean, some decisions are made by individuals. If it turns out to be a slightly larger level problem, then they might be made at the departmental level. Although, when you speak of departments at Springfield, they really don't function at any level above just being designations for what kind of medicine will practice. Most departments, when I was there, were not meeting on a regular basis. They were not setting policy for themselves.

So, often problems would be pushed up to the level of the chief of health programs, and occasionally that would result in the problem or the issue being discussed at a medical staff meeting but, more likely than not, the chief of health programs would simply make the decision by him or herself.

Mr. HUGHES. Were there regular staff meetings?

Dr. LANDUCCI. There were regular medical staff meetings, yes—

Mr. HUGHES. Does the medical director participate in those?

Dr. LANDUCCI. Yes.

Mr. HUGHES. How about the warden or deputy warden?

Dr. LANDUCCI. No. That was an interesting thing, in that shortly after I arrived there, the medical staff closed the meetings to all nonphysicians. I mean, the pharmacist could not come, the nurses could not come, certainly no nonmedical staff could come to these meetings.

Mr. HUGHES. Was there any input, any systematic input, by other practitioners, nurses—

Dr. LANDUCCI. The chief of health programs would take the information from the staff meetings, the medical staff meetings, and disseminate it to appropriate people, but that was not a reliable mechanism. I mean, it was often decided that would be done, but he acted as an individual with an individual agenda. So, it was not always that such matters would be discussed with all the involved parties.

I should also point out that some of the decisions were made by the warden or the associate warden and passed down to the medical staff. If they felt that it was necessary to deal with an area that was being ignored or overrule something that was being done by the medical staff, then it was taken on by them.

Mr. HUGHES. Did the physician assistants participate in those medical meetings?

Dr. LANDUCCI. Not ever that I can recall.

Mr. HUGHES. Were there any organized meetings of the physician assistants?

Dr. LANDUCCI. In Springfield, the physician assistants operate in the—at that time I believe it was called the outpatient care department, and they were overseen by the person, the physician who was in charge of that department. So, they would meet regularly with that physician, but not as a department of themselves or as a group of themselves.

Mr. HUGHES. Did they perform postmortems, autopsies while you were at Springfield?

Dr. LANDUCCI. When I was at Springfield, there was initially no policy regarding the performance of autopsies. After I had been at Springfield for less than a year—in fact, probably about 6 months—there were great restrictions placed on when an autopsy could be performed. Ultimately, within a few months of those restrictions being put into effect, the chief of health programs arbitrarily decided that autopsies would cease to be done altogether, no matter what the circumstances.

Mr. HUGHES. Under any circumstances?

Dr. LANDUCCI. Exactly.

Mr. HUGHES. When was that? When was that order put in place, if you recall?

Dr. LANDUCCI. That's just a rough estimate, but I would have say it was in the early part, probably February 1988.

Mr. HUGHES. And, what was the medical reason for that?

Dr. LANDUCCI. Well, there was a series of events that led to that decision being made. It reflects a lot on how Springfield functions.

When I first arrived at Springfield, I was at that time the only new internist in the department; later I was joined by other staff. I'm very aggressive about getting autopsies done on patients who die on my services, and continue to do so. There were actually two motivating factors that led to a significant discussion of this. One of them was that they saw the rate of autopsies being performed increasing, and there was resistance on the part of medical staff to subject themselves to this kind of scrutiny, in addition to which there was resistance from the contract pathology service who

claimed that there was just too much of a risk in performing autopsies for these patients.

The restrictions were imposed on performing autopsies, and ultimately I chose to not declare a patient dead at the institution. The policies of the institution required that I do that, which by the fact that I didn't do it resulted in the need to implement a Missouri State statute which required an autopsy under those circumstances.

When that happened, there were serious repercussions leading the chief of health programs to arbitrarily decide that no further autopsies would be authorized under any circumstances. And, the policy regarding who could declare people dead in the institution was also changed at that time, so that it was liberalized.

Mr. HUGHES. The medical director at Springfield made that decision essentially?

Dr. LANDUCCI. Yes, exactly.

Mr. HUGHES. Reviewed by headquarters?

Dr. LANDUCCI. No, I don't think that he ever passed it by the staff at headquarters. In fact, I'm fairly certain that they were not aware that this was done.

Mr. HUGHES. I think that's all the questions I have.

Thank you very much. I appreciate your contributions. I apologize for the way this was dragged out today, but we've had a number of votes and the break for lunch, and the testimony of the first panel went a little longer than anticipated. So, thank you very much for your patience and your contributions, particularly you, Dr. Thorburn. I know you've traveled a long distance to be with us, and we appreciate it very much.

Dr. THORBURN. Thank you.

Mr. HUGHES. Thank you.

That concludes the hearing for today. The subcommittee stands adjourned.

[Whereupon, at 4:20 p.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

APPENDIX 1.—LETTER FROM CHAIRMAN WILLIAM J. HUGHES, TO J. MICHAEL QUINLAN, DIRECTOR, BUREAU OF PRISONS, AUGUST 1, 1991

(137)

ADDITIONAL QUESTIONS FOR THE FEDERAL BUREAU OF PRISONS

1. I understand that there is a wellness program component to the Bureau's drug treatment programs. Do you have a plan to institute a wellness program for the entire inmate population?

2. Does the Bureau of Prisons have the authority to release inmates who are terminally ill and close to death?

How many inmates have been given compassionate release over the past year, and what kinds of circumstances and illnesses did these inmates have?

3. There are likely to be as many community standards of medical care as there are communities in the United States. How does the Bureau of Prisons define community standard?

4. In what ways do you think prison health care differs from health care in a community setting?

5. Can you describe the kinds of security problems that prisons face in providing care for inmates? For example, what are the difficulties that medical staff face in treating a Marion inmate who may be prone to violence?

6. What is the basic medical treatment and diagnostic screening that all inmates receive, assuming that they never show up at sick call?

7. What is the basic care for women? Does it include a regular gynecological examination?

8. There are certain treatments that I understand the Bureau of Prisons to consider outside the scope of required medical care. Do you permit inmates, who have the necessary resources, to obtain the treatment at no cost to the Bureau? I am thinking, for example, of an inmate who may seek a kidney or heart transplant.

9. How many deaths have there been at Springfield this year? What were the causes of the deaths? What kind of review has the Bureau conducted in each of these cases? How many autopsies were performed on patients who died?

10. Is there a committee of qualified doctors that screens applicants to determine whether they meet the Bureau of Prisons' standards?

11. What are the licensing requirements for Bureau physician assistants?

12. How many of the Bureau's doctor's have affiliations with teaching hospitals?

13. What does your medical staff recruitment practice entail?
14. Have you surveyed medical professionals in the Bureau of Prisons to determine whether there are any aspects of working conditions that could be improved?
15. Has the number of doctors increased in the same proportion as the prison population?
16. Do you have a full time gynecologist on staff at the Lexington Federal Correctional Institution?
17. When was the Office of Quality Management established? Could you describe its structure and how it investigates cases where there is a questionable medical outcome?
18. What specific plans do you have to incorporate external auditors into your quality review program?
19. Does the Bureau of Prisons have any protocol regarding when a patient is seen by a doctor after being seen by a physician assistant?
20. What medicines can a physician assistant prescribe?
21. A number of health care experts have questioned the approach of considering all staff, including doctors and other medical professionals as correctional officers first, and health care workers second. What exactly does this mean for all staff to be correctional officers, and do you see any benefit to creating a clear division between the health care workers and correctional officers?
22. Is the Bureau of Prisons' medical budget independent from the rest of the Bureau's operating and administrative budget? Does the medical director have ultimate say over the budget, or is it controlled by the director of the Bureau?
23. Has the Bureau of Prisons studied problems with the medical transport system, such as transportation of ill prisoners with their records or necessary medication? Have you made any changes in these procedures in recent years to address concerns that have been raised?
24. What inmates are transported by bus and what inmates are transported by airlift? What are the factors that lead to this determination?
25. Please explain the procedure for inmates to file complaints about medical care, beginning with the informal process and ending with litigation.

26. How many inmate grievances were filed in 1990? How many of these related to medical care?

27. What are the major complaints that inmates make regarding medical care?

28. The recent National Commission on AIDS Report, "HIV Disease in Correctional Facilities," recommended that prisons establish HIV education programs. Does the Bureau of Prisons have an AIDS education plan, and what does this entail?

29. What are the Bureau's policies regarding disclosure of HIV test results to Bureau employees and others outside the prison without first obtaining the consent of the prisoner?

30. Does the Bureau of Prisons allow inmates with AIDS to participate in clinical drug trials?

31. At what stage do you provide inmates who are HIV positive with AZT treatment?

32. What is the Bureau of Prisons policy regarding segregation of inmates with AIDS?

33. It is our understanding that you are reviewing a decision made earlier this year not to purchase an acute care hospital in Texarkana. What is the status of that review?

34. If the Bureau got possession of the hospital in Texarkana, how would it be used?

35. Are there unmet medical needs in the Bureau's system that could be met by a new prison hospital in Texarkana?

APPENDIX 2.—LETTER FROM J. MICHAEL QUINLAN, DIRECTOR, BUREAU OF
PRISONS (WITH ATTACHMENTS), TO CHAIRMAN WILLIAM J.
HUGHES, SEPTEMBER 16, 1991

September 16, 1991

William J. Hughes
Chairman
Subcommittee on Intellectual Property
and Judicial Administration
Committee on the Judiciary
207 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Hughes:

Thank you for your letter dated August 1, 1991, and the attached questions that follow up on the recent Subcommittee hearing regarding health care in the Bureau of Prisons.

In addition to the questions you pose, during my testimony, I indicated I would provide details on three issues as part of our response for the record. First, you asked for a breakdown of physician vacancies in the Bureau of Prisons with psychiatrist vacancies being separately identified. Attachment I gives that information, and is provided to help clarify the record as there was conflicting testimony regarding the number of physician positions and the number of vacancies.

You also asked for statistics on our Continuing Professional Education Program that show allotments by category, and involvement in terms of dollars and numbers of health care providers using the funds. Attachment II provides that information.

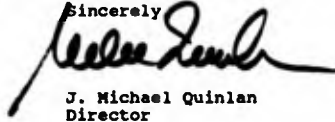
Finally, you inquired about our policy on performing autopsies. We perform autopsies in the interest of practicing the highest standard of medicine. Based on Joint Commission on Accreditation of Healthcare Organization standards, we secure as high a percentage of autopsies as possible. We order autopsies in the following situations: (1) in the event of a homicide, suicide, fatal illness, accident, or unexplained death in order to detect a crime, maintain discipline, protect the health and safety of other inmates, remedy official misconduct, or defend against civil liability; and (2) if there is written consent of a person authorized to permit the autopsy under the law of the applicable State.

- 2 -

The questions that you included with your letter are reiterated and answered in attachment III.

I appreciated the opportunity to provide the Subcommittee with information about our health care delivery system. Please contact me if I can be of any further assistance.

Sincerely

A handwritten signature in dark ink, appearing to read "J. Michael Quinlan", written in a cursive style.

J. Michael Quinlan
Director

Attachment I

Bureau of Prisons Physician Staffing Information
On July 1, 1991

<u>Category</u>	<u>Authorized Positions</u>	<u>Positions Filled</u>	<u>Vacancies</u>	<u>Fill-Rate</u>
Non-psychiatric physicians	123	109	14	89 %
Psychiatrists	30	20	10	67 %
-----	-----	-----	-----	-----
Total physicians	153	129	24	84 %

Attachment II

Continuing Professional Education
Funds Analysis for FY 1991 as of August 6, 1991

Care Provider Category	Number of Positions	Total Funds Allocated	Capitation Funds Per Provider	Use in Number	Use in Percent
Physicians	135	\$ 145,305	\$ 1400	85	63%
Nurses	325	99,249	500	296	91%
Physician Assistants (Certified)	164	139,467	1000	80	49%
Physician Assistants (Non-certified)	265	136,524	600	137	52%
Dentists	107	67,548	1000	72	67%
Pharmacists	72	24,944	600	42	58%
Dietitians	8	1,411	500	4	50%
Medical Record Professionals	104	28,926	350	65	63%
Physical Therapists	6	2,986	450	5	83%
Health Services Administration	164	44,451	---	46	28%
Lab Technicians	14	3,082	---	3	21%
Dental Technicians	10	500	---	10	100%
Radiology Technicians	10	1,920	---	2	20%
Medical Technologists	16	1,814	---	4	25%
Social Workers	7	810	---	1	14%
Dental Hygienists	13	1,334	---	3	23%
Dental Assistants	3	450	---	1	33%
Totals	1419	\$ 700,721 ¹	---	856	60%

¹ Due to additional training, such as Advanced Cardiac Life Support and professional education approved on an individual basis, all of the \$750,000 in funds allocated for FY 1991 have been spent.

Attachment III

Additional Questions for the Federal Bureau of Prisons

1. I understand that there is a wellness program component to the Bureau's drug treatment programs. Do you have a plan to institute a wellness program for the entire inmate population?

Response:

The comprehensive Inmate Drug Treatment Program is a voluntary program in which a participant completes 100 hours of wellness training. The training consists of relapse prevention, anger management, fitness management, and stress management. This program is suited for those inmates who have prior drug-related problems.

We plan to implement a comprehensive health promotion and disease prevention program for the entire inmate population. Our conceptual design for this program includes initiatives to increase inmates' awareness of health risks, testing and screening for health problems, aggressive disease prevention treatment protocols and individualized regimens, and education on positive and healthy decision-making to enhance the quality of inmates' lives.

We currently operate a number of inmate health promotion programs under a "wellness" theme, and we have developed components of other programs with wellness specifically in mind. Because wellness is often associated with physical fitness, recreation is a major program offering to inmates. Recreation departments at our institutions establish group sports activities and offer opportunities for individual fitness programs, as well as leisure and hobby craft activities.

As part of our medical mission, we currently endorse and champion the concepts of health promotion and disease prevention under more specific services. Our health care system offers programs in preventive health care such as chronic care clinics where health education is espoused to inmates with particular medical needs. Our food service program promotes and emphasizes heart healthy diets. We are engaged in nutrition education and provide several mediums where inmates are made aware of the nutritional value of certain foods. We prepare food using little fat and salt and offer alternatives to fried foods. We encourage inmates to make wise dietary choices, and offer fresh fruit and salad bars to complement meals.

Attachment III

- 2 -

2.a. Does the Bureau of Prisons have the authority to release inmates who are terminally ill and close to death?

Response:

Under Title 18 U.S.C., section 3582(c), and from a request initiated by the Bureau of Prisons, a sentencing court can reduce an inmate's minimum term of the sentence to time served. The Bureau uses this legal provision in cases where unusual circumstances evolve -- circumstances that could not reasonably have been foreseen by the Court at the time of sentencing. We have used this provision in many cases where an inmate became terminally ill.

2.b. How many inmates have been given compassionate release over the past year, and what kinds of circumstances and illnesses did these inmates have?

Response:

Seventeen inmates were released on compassionate grounds over the past year. Their illnesses were AIDS, cancer, and heart disease.

3. There are likely to be as many community standards of medical care as there are communities in the United States. How does the Bureau of Prisons define community standard?

Response:

Because we are a national system, our standard for medical services is not defined by the community where a particular facility is located. The level and types of care we provide are based on nationally-recognized standards of care and practices derived from promulgations by national organizations such as the Department of Health and Human Services, the Centers for Disease Control, the American Medical Association, the Joint Commission on Accreditation of Healthcare Organizations, and the American Correctional Association.

4. In what ways do you think prison health care differs from health care in a community setting?

Response:

The health care we provide to Federal inmates differs from care provided in the community in five major ways. First, we provide only medically mandatory or medically necessary care. This includes care without which an inmate might experience deterioration of a condition, a reduced chance of recovery, or

Attachment III

- 3 -

significant pain or discomfort. Unless there is a specific medical or other indication, we do not routinely provide care that may be medically acceptable, but not currently necessary, or care that is purely cosmetic in nature.

Second, inmates often attend to their wants, rather than health care needs. There are few costs or disincentives to counter overuse of an essentially free system. Third, inmates do not have personal choice regarding the selection of their care provider. Inmates may refuse care, but cannot select their provider in the institution.

Fourth, inmates currently do not incur any financial responsibility for their care. Medical care is provided at the expense of the Government. Finally, the Bureau is required to provide and ensure that certain health screening and infectious disease tests are done irrespective of the inmate's approving of the test.

5. Can you describe the kinds of security problems that prisons face in providing care for inmates? For example, what are the difficulties that medical staff face in treating a Marion inmate who may be prone to violence?

Response:

All staff are required to ensure compliance with the appropriate custodial practices related to the security level of an inmate. Some issues that are addressed when providing medical care to high-security or violence-prone inmates are: (1) the application and removal of restraints for treatment and diagnostic procedures, (2) maintaining confidentiality while ensuring there are sufficient correctional staff to prevent injury to the care provider, and (3) some community facilities will not contract with us to provide medical services due to concerns about security and safety.

6. What is the basic medical treatment and diagnostic screening that all inmates receive, assuming that they never show up at sick call?

Response:

Each inmate will have a complete physical within the first 30 days of admission to the Bureau. This includes a medical history, physical examination, chest X-ray, dental examination, tuberculosis test, blood tests, and serology tests. The inmate will be re-examined before being placed into specialized work

Attachment III

- 4 -

environmente such as high-noise aree or food eervice. In addition, inmates under age 50 are offered a biennial physical, while inmates over the age of 50 are offered an annual phyiecal. Inmatee in segregation status or in secure housing units are seen in their unit by a phyieician aseietant 7 days a week. These inmatee may refuse care, but will at least be visually and verbally contacted by a health care provider every day.

7. What ie the basic care for women? Does it include a regular gynecological examination?

Response:

The baecic care for women includes all the physical examination and screening exame afforded any inmate in the Bureau. In addition, a female inmate will have a gynecological and obetetrical history taken, and a pelvic and breaet examination done. Laboratory tests are augmented to include a PAP smear, gonorrhea culture, vaginal smear for chlamydia, a shielded chest X-ray, and a pregnancy test. We offer measles, mumps, and rubella vaccines to all non-pregnant sentenced female inmates of childbearing age. Annual PAP smears, pelvic exams, and breast exams are offered according to American College of Obstetrics and Gynecology standards. We also offer annual mammographiiee to women over the age of 50.

8. There are certain treatments that I understand the Bureau of Prieone to consider outside the ecope of required medical care. Do you permit inmates, who have the necessary resources, to obtain the treatment at no coet to the Bureau? I am thinking, for example, of an inmate who may seek a kidney or heart transplant.

Response:

We will allow an inmate to obtain an organ transplant at pereonal expense as long ae: (1) a transplant is the recommended couree of treatment, (2) the inmate ie shown no special consideration over othere seeking the organ, and (3) the inmate, his or her family, or a third party provider pays all preoperative, operative, and postoperative costs, including any costs associated with security considerations. The Medical Director must review and approve all requests for transplante.

Attachment III

- 5 -

9. How many deaths have there been at Springfield this year? What were the causes of the deaths? What kind of review has the Bureau conducted in each of these cases? How many autopsies were performed on patients who died?

Response:

There have been 31 deaths at MCFP Springfield so far this year. The causes of these deaths are: cardiorespiratory failure or heart disease (11), AIDS or AIDS-related diseases (10), cancer (6), liver failure (1), renal failure (1), hepatitis (1), and asphyxiation by hanging (1). In many of these deaths there was more than one cause, such as cancer leading to cardiopulmonary arrest. The primary cause is indicated above. MCFP Springfield physicians other than the treating physician conduct extensive reviews on all deaths. Nine autopsies were performed on these 31 cases. The rate of autopsies at MCFP Springfield is lower than the rate at our non-medical referral centers because the causes of these deaths are more often unquestioned.

10. Is there a committee of qualified doctors that screens applicants to determine whether they meet the Bureau of Prisons' standards?

Response:

The Health Services Division's Office of Quality Management screens all applicants to determine their qualifications for appointment as physicians in the Bureau of Prisons. The Office of Quality Management is headed by a physician who is board-certified in medical quality assurance.

11. What are the licensing requirements for Bureau physician assistants?

Response:

Physician assistants who have training at American Medical Association approved schools and physicians who have graduated from foreign medical schools are eligible to apply as physician assistants in the Bureau of Prisons. While there are no licensing requirements for physician assistants to practice, they can only practice under the supervision of a licensed physician, and we strongly encourage physician assistant certification.

Attachment III

- 6 -

12. How many of the Bureau's doctor have affiliations with teaching hospitals?

Response:

We have 6 physicians who are affiliated with teaching hospitals. The following table notes their location and affiliation.

<u>Institution</u>	<u>Affiliation</u>
MDC Los Angeles	UCLA
FPC Alderson	West Virginia School of Osteopathy
FCI Lexington	University of Kentucky
FCI Danbury	Danbury Community Hospital
FCI Terminal Island	Memorial Medical Center, Long Beach
FPC Bryan	Texas A&M

13. What does your medical staff recruitment practice entail?

Response:

The Health Services Division's Recruitment Section is involved in several activities. During FY 1991, we set up and staffed a recruitment booth at 30 major medical conventions, mailed 200,000 letters to physicians listed with the American Medical Association, and visited several universities to hire health care interns. We track health care position allocations to, and vacancies within, our institutions. We initiate referrals of applicants and follow up on their progress with particular attention on hard-to-fill positions and locations.

Our staff follows up on approximately 25 leads each day by phone and by letter. We have coordinated over 200 institution visits by interested medical professionals. We have contacts with the Public Health Service and extensively use the Commissioned Officer Student Extern and Training Program as a recruitment tool.

14. Have you surveyed medical professionals in the Bureau of Prisons to determine whether there are any aspects of working conditions that could be improved?

Response:

As part of the efforts of a Staff Retention Work Group we formed last year, we conducted two surveys of our health care providers. The results of those surveys indicate primary concern in the

Attachment III

- 7 -

areas of facility space and equipment needs, secretarial support, and physician back-up services. We are aggressively addressing each of these areas. We are surveying all health services units to determine facility and equipment needs, and will develop plans of action for expansion and enhancements where indicated. We continue to urge institutions to staff health services to established guidelines that include appropriate secretarial support. We also urge institutions to hire two physicians or develop back-up contracts with community providers. Also, we are pursuing a pilot substitute physician program for additional physician back-up services.

15. Has the number of doctors increased in the same proportion as the prison population?

Response:

In general, yes. In 1990, we had 53,000 inmates and 124 physicians, or a ratio of 1 physician for 427 inmates. In 1991, we have 60,000 inmates and 129 physicians, or a ratio of 1 physician for 465 inmates.

16. Do you have a full time gynecologist on staff at the Lexington Federal Correctional Institution?

Response:

Yes. Our full-time gynecologist at FCI Lexington is board certified in obstetrics and gynecology.

17. When was the Office of Quality Management established? Could you describe its structure and how it investigates cases where there is a questionable medical outcome?

Response:

The Office of Quality Management was established on May 1, 1991, and is under the direct supervision of a Senior Deputy Assistant Director. The Office currently has two positions and is responsible for the implementation and oversight of medical quality assurance programs.

All deaths are reviewed by our Quality Management Advisory Group, which also serves as the Mortality Review Committee, which consists of several senior Bureau physicians and an outside expert clinical consultant. We perform a focused review in the

Attachment III

- 8 -

case of a questionable death or other questionable medical outcome. Focused reviews are conducted by ad hoc groups of senior physicians, health services administrators, and correctional administrators.

18. What specific plans do you have to incorporate external auditors into your quality review program?

Response:

The Health Services Division has adopted a number of quality review programs for continuous improvement of the quality of medical care. External experts serve as panel members on the Mortality Review Committee that reviews all inmate deaths, on certain focused review committees, in the external peer review process, on committees determining clinical practice guidelines, and in the external accreditation process through medical center accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

19. Does the Bureau of Prisons have any protocol regarding when a patient is seen by a doctor after being seen by a physician assistant?

Response:

While the physician assistant is usually the first contact person for delivery of health care, the physician is ultimately responsible for the medical care of each inmate. A physician is available for consultation during sick call. Inmates who specifically request to see a physician may do so, and the physician will schedule the inmate for an appointment. Other health services staff may also refer non-emergency visits to the physician for more detailed evaluation.

20. What medicines can a physician assistant prescribe?

Response:

The institution physician completes a qualifications brief and privileges statement on all physician assistants delineating their scope of practice. The physician determines any limits to the prescribing of medication based on the qualifications and experience of the individual physician assistant. In general, medications that are not sold over-the-counter require the review and signature by the physician before the medication can be initiated or renewed.

Attachment III

- 9 -

21. A number of health care experts have questioned the approach of considering all staff, including doctors and other medical professionals as correctional officers first, and health care workers second. What exactly does this mean for all staff to be correctional officers, and do you see any benefit to creating a clear division between the health care workers and correctional officers?

Response:

To consider all employees as correctional workers first and more job-specific categorical professionals second means two things. First, it means that Bureau employees are not as susceptible to the problems of role conflict expressed by some correctional systems' employees who see major dissonance in their ability to provide care or therapy in a security-intense environment. Second, it means all Bureau employees are trained in security matters and are required to respond to emergencies. This is reassuring to staff and creates a safer, more secure, and more comfortable environment in which to work.

We see very little benefit to creating a clear division between health care workers and correctional officers. Care providers must maintain a continuous intellectual balancing of behavior while on the job to determine whether a care or custody role must dominate in any specific action or decision. We feel that, to provide quality care in a prison setting, the role of health care advocate requires the development of this balance between necessary medical care and security considerations. As with all staff, through continuing awareness and sensitivity, health care providers must be ever on the alert for inmate attempts to manipulate or breach security through inappropriate use of the health care system, while maintaining a professional commitment to provide the highest level of care.

22. Is the Bureau of Prisons' medical budget independent from the rest of the Bureau's operating and administrative budget? Does the Medical Director have ultimate say over the budget, or is it controlled by the Director of the Bureau?

Response:

The medical budget is part of the Bureau's operating budget. As a member of the Executive Staff, the Medical Director has great input to the budget; however, the Director makes the final decision on budgetary allocations.

Attachment III

- 10 -

23. Has the Bureau of Prisons studied problems with the medical transport system, such as transportation of ill prisoners with their records or necessary medication? Have you made any changes in these procedures in recent years to address concerns that have been raised?

Response:

Yes. We have examined the medical transportation system from both an internal perspective and through an external expert evaluation of our health care system. We have made significant recent changes in our administration of patient transportation in order to improve efficiency, reduce transportation time, and assure appropriate modes of transportation based on a patient's clinical status.

Regarding patient transportation in general, in 1985, we created the position of medical designator to address problems associated with the appropriate designation of inmates with health problems. We formed a medical transportation work group in 1989 to specifically address the issue. One result of that group's efforts was the formation of the Office of Medical Designations and Transportation. This Office provides coordination in the movement of inmates with medical problems and is conducting a study on medical transportation issues. The Office was relocated to a site adjacent to our Medical Center for Federal Prisoners in Springfield, Missouri in order to better coordinate transportation issues with the U.S. Marshals Service in Oklahoma City, Oklahoma.

This year, the Office was reorganized and retitled the Office of Managed Care. The Managed Care Branch is responsible for the coordination of all medical and mental health designations, patient transfers, and tracking of placements in community hospitals. The Managed Care Branch arranges air ambulance transportation to a Bureau Medical Referral Center or to a community hospital when needed. We are planning to build a secure transportation hub facility with medical assets in Oklahoma City, Oklahoma, to facilitate the movement of inmate-patients. The U.S. Marshals Service, which provides the air transportation, is also improving their facilities at Oklahoma.

Attachment III

- 11 -

24. What inmates are transported by bus and what inmates are transported by airlift? What are the factors that lead to this determination?

Response:

The institution physician evaluates the condition of each patient to be transferred. If their condition permits, they are transported by routine means on Bureau of Prisons' buses or on the U.S. Marshals Service aircraft. If their condition warrants immediate transfer, inmates are classified as urgent or emergency cases and are moved directly to treatment facilities by either air ambulance, air charter, ground ambulance, or institution vehicle. The factors that determine the mode of transportation are the seriousness of the illness, the patient's condition, age, length of time before treatment should be implemented, and the patient's physical ability to board and deplane aircraft with assistance.

25. Please explain the procedure for inmates to file complaints about medical care, beginning with the informal process and ending with litigation.

Response:

Inmates may discuss, attempt to resolve, or file a complaint on virtually any subject related to their confinement. The Bureau espouses the accessibility of managers and administrators at all levels to handle concerns in a proactive manner. At a minimum, staff from all departments are available every day during the afternoon meal. At this time, inmates can discuss their concerns with a member of the health services staff. Resolution of complaints are initiated with the inmate's correctional counselor. If the inmate is not satisfied with the results of the informal resolution, the inmate initiates the formal process with the correctional counselor.

The first level of the formal administrative remedy process begins with the Request for Administrative Remedy. The complaint is filed at the institution and the Warden responds to the complaint within 15 days. If not satisfied with the response, an inmate may appeal the institution's decision to the Regional Office. The Regional Office answers within 20 days. If the inmate is not satisfied with the Region's response, he may appeal to the Central Office.

The Central Office responds within 30 days and the response is considered the final agency decision. Once an inmate receives a

Attachment III

- 12 -

response from the Central Office, he has exhausted all internal administrative remedy procedures. The next avenue of redress is litigation. Most courts will decline to address the claim unless the inmate has pursued a complaint through all levels of the Bureau's administrative remedy process.

26. How many inmate grievances were filed in 1990? How many of these related to medical care?

Response:

A total of 10,760 grievances were filed at our institutions in 1990. Of these, 988 (9.2%) related to medical concerns. Of the original 10,760 grievances filed, 2951 advanced to the Central Office through the appeal process. Of the 2,951 appealed to the Central Office, 165 (5.5%) related to medical issues.

27. What are the major complaints that inmates make regarding medical care?

Response:

The major complaints inmates make regarding medical care are: (1) dissatisfaction with specific treatment or dissatisfaction with the regimen of evaluation and treatment, (2) demands for specific medications or treatments based on desire rather than clinical indications, (3) disagreement with the delivery of medical care remaining within the Bureau rather than being handled by a community consultant, (4) the inability to retain a private physician for delivery of health care, and (5) the denial of purely elective or cosmetic procedures.

28. The recent National Commission on AIDS Report, "HIV Disease in Correctional Facilities," recommended that prisons establish HIV education programs. Does the Bureau of Prisons have an AIDS education plan, and what does this entail?

Response:

The Bureau has an HIV/AIDS educational program that emphasizes discussions and interactive presentations to supplement our videotape presentations and pamphlets. Education is provided to all inmates upon arrival into the prison system and is also offered on a quarterly basis. Employees receive education upon initial employment and then yearly during annual refresher training.

Each institution provides inmates and staff with knowledge and understanding of the human immunodeficiency virus, its

Attachment III

- 13 -

transmission, and AIDS. Institutions have latitude in individualizing their programs to fit particular language or cultural needs. While we provide some standardized information that must be conveyed, local enhancements result in presentations that are more responsive to both immediate and changing needs.

29. What are the Bureau's policies regarding disclosure of HIV test results to Bureau employees and others outside the prison without first obtaining the consent of the prisoner?

Response:

The Bureau stresses confidentiality and only selected staff have knowledge of an inmate's HIV status. At the institution, this is the Warden, the Clinical Director, and other health care staff who would be providing counseling. Prior to release from prison or placement in a community correctional center, we alert the Unit Manager, the U.S. Probation Officer, and the Bureau's Community Corrections Manager. These individuals are included in the definition of "need to know" because they require the information in order to make appropriate selections regarding community placement and follow-up access to medical care.

30. Does the Bureau of Prisons allow inmates with AIDS to participate in clinical drug trials?

Response:

Federal inmates may participate in clinical trials or extended access programs if they are recommended for inclusion by their institutional physician and if the request is approved by the Bureau's Medical Director. Patients' inclusion in a clinical trial is based on their failure to respond to conventional or acceptable therapies.

31. At what stage do you provide inmates who are HIV positive with AZT treatment?

Response:

Inmates who are HIV-positive and have CD4 levels of 500 or less are candidates for AZT therapy.

Attachment III

- 14 -

32. What is the Bureau of Prisons policy regarding segregation of inmates with AIDS?

Response:

Inmates who have AIDS are usually housed in one of our medical centers where they receive specialized care. If their condition does not warrant hospitalization, they remain at our regular institutions and are cared for by the resident medical staff. Inmates who are HIV-positive or have AIDS are not segregated nor quarantined unless they demonstrate behavior which threatens the health of others.

33. It is our understanding that you are reviewing a decision made earlier this year not to purchase an acute care hospital in Texarkana. What is the status of that review?

Response:

We have been contacted by a representative of the Texarkana hospital who will provide additional information. When that information arrives, we will determine if further review is necessary.

34. If the Bureau got possession of the hospital in Texarkana, how would it be used?

Response:

At this time, we feel that it would be extremely difficult to make efficient and effective use of the hospital in Texarkana. This is what prompted our original decision to decline the hospital's offer. The hospital does not meet many of the criteria the Bureau uses in selecting a site for a hospital. It does not have adequate transportation connections, it is not suitable for conversion to a secure facility, there is not enough space to house an inmate work cadre, and the community lacks sufficient medical resources to provide the support and services necessary for a medical referral center.

35. Are there unmet medical needs in the Bureau's system that could be met by a new prison hospital in Texarkana?

Response:

There are unmet medical needs in the Bureau; however, they could not be met in an effective and efficient manner by the facility in Texarkana.

APPENDIX 3.—LETTER FROM J. MICHAEL QUINLAN, DIRECTOR, BUREAU OF PRISONS, TO CHAIRMAN WILLIAM J. HUGHES, OCTOBER 10, 1991



U.S. Department of Justice

Federal Bureau of Prisons

Office of the Director

Washington, DC 20534

October 10, 1991

William J. Hughes
Chairman
Subcommittee on Intellectual Property
and Judicial Administration
Committee on the Judiciary
207 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Hughes:

In your opening comments at the July 17 hearing on health care in the Bureau of Prisons, you stated that an inmate in the Federal Medical Center (FMC) in Lexington, Kentucky recently wrote to you about her medical condition. This inmate stated that after over 2 years of medical problems and complaints, she was diagnosed as having ovarian cancer, and that the cancer had spread so extensively that, even with regular chemotherapy treatments, she may have less than 1 year to live.

We researched the case of Stella Young. Stella Young is a 65 year old white female who entered our system on December 5, 1987 as a pretrial detainee at our Metropolitan Correctional Center (MCC) in San Diego, California. She had several contacts with physician assistants at MCC San Diego primarily for arthritis and medication refills, but also for complaints of colds.

According to her medical record, Mrs. Young received an admission screening exam, but did not receive a complete admission physical and was only seen by physician assistants during her detention at MCC San Diego. She did have certain diagnostic tests performed including a chest X-ray on December 19, 1988. She had no gynecological complaints while at MCC San Diego. Her history indicates that she was a moderate smoker and had not availed herself of mammographies, or pelvic exams and the associated laboratory tests for 20 years prior to her incarceration.

Mrs. Young was sentenced and transferred to FMC Lexington on January 9, 1989. She received an admission physical on January 24, 1989. Part of the total admission physical regimen includes referral to the gynecologist for examination. At that time, FMC Lexington did not have a full-time gynecologist on staff.

- 2 -

Mrs. Young was referred to the consultant gynecologist and scheduled for gynecological evaluation on April 6, 1989. She failed to keep her appointment, and failed to keep a rescheduled appointment on April 19. We made no further attempt at pursuing the gynecological examination.

In the fall of 1989, after suffering some unusual vaginal bleeding, she was diagnosed with ovarian and endometrial cancer. Specialists from the University of Kentucky Medical Center performed surgery on January 31, 1990.

Mrs. Young began receiving chemotherapy treatment following the 1990 surgery. Prior to the cessation of chemotherapy in December 1990, recurrence of the cancer was confirmed upon readmission to the University of Kentucky Medical Center. Mrs. Young began a second course of chemotherapy in January 1991 and continues on that treatment regimen.

Mrs. Young did not suffer 2 years of problems and complaints before diagnosis, but rather has undergone approximately 2 years of treatments and therapy since diagnosis. Mrs. Young's response to chemotherapy has not been good. In consultation with the gynecology and oncology staff at the University of Kentucky Medical Center, medical personnel place Mrs. Young's life expectancy at less than 1 year. Medical personnel at FMC Lexington have recommended and the institution is pursuing a reduction in sentence under the provisions of 18 U.S.C. Section 4205(g).

I trust this information elaborates the medical care we provided and our current attempt at an early release in this case. Please contact me if I can answer any questions in this matter.

Sincerely,



/J. Michael Quinlan
Director

APPENDIX 4.—LETTER AND MAGISTRATE'S REPORT AND RECOMMENDATION
FROM MARK D. STREED, ESQ., MESHBESHER & SPENCE, LTD.,
TO ELIZABETH FINE, ASSISTANT COUNSEL, SUBCOMMITTEE ON
INTELLECTUAL PROPERTY AND JUDICIAL ADMINISTRATION,
SEPTEMBER 10, 1991

LAW OFFICES
MESHBESHER & SPENCE, LTD.

1006 PARK AVENUE

MINNEAPOLIS, MINNESOTA 55404

(612) 336-9681

FAX (612) 336-9680

HERBERT MESHBESHER*
RONALD L. MESHBESHER
RUSSELL M. SPENCE*
JAMES H. OILBERT*
JOHN P. CLIFFORD
DEBBIE H. JOHNSON***
JACK MCGHEE
PAUL W. MONTGOMERY
PATRICK E. MORAN

REPLY TO MINNEAPOLIS OFFICE

DANIEL J. BOIVIN**
MICHAEL C. SNYDER*
JAMES A. WELLNER
JOHN P. HENRY
MARK D. STREED
RANDALL G. SPENCE
HOWARD I. BARE
DANIEL C. GUSSENBERG
J. H. IVET***
KATHERINE S. FLOM
JOHN L. GREEN

*ALSO ADMITTED TO
PRACTICE IN MINNESOTA

**ALSO ADMITTED TO PRACTICE
IN MINNESOTA & NORTH DAKOTA

September 10, 1991

**ALSO ADMITTED TO
PRACTICE IN ILLINOIS

***ALSO ADMITTED TO
PRACTICE IN TEXAS

Ms. Elizabeth Fine
c/o William J. Hughes
Chairman, Subcommittee on Intellectual
Property and Judicial Administration
207 Cannon Building
Washington, D.C. 20515

Re: Mayley v. United States
Our File No. 8952-26247

Dear Ms. Fine:

Enclosed you will find a copy of the Magistrate's Report and Recommendation concerning the summary judgment motions brought by the United States on Sidney Mayley's case. We briefed and argued these motions approximately two months ago and just recently received the Magistrate's report. As you can see, the Magistrate ruled against the United States on all counts. There is some pretty good language in the Magistrate's report which you may find interesting.

I will keep you posted on any new developments with Sidney's case. If you have any questions or comments feel free to call me.

Very truly yours,

Mark D. Streed

MDS/dmb
Enclosure

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
FOURTH DIVISION

Sidney Mayley,

CV No. 4-89-929

Plaintiff,

v.

REPORT & RECOMMENDATION

United States of
America, The Federal
Bureau of Prisons, Warden
J.B. Bogan, Dr. James
Bastron and Dr. P.E.
Bernatz,

Defendants.

Plaintiff, a federal prisoner, has asserted Federal Tort Claims and civil rights claims against the government related to certain medical care he received while he was incarcerated at the Federal Medical Center in Rochester, Minnesota. The matter has been referred to the undersigned United States Magistrate Judge for report and recommendation pursuant to 28 U.S.C. §636 and Local Rule 72.1(c). Defendants have filed a motion to dismiss or, in the alternative for summary judgment. A hearing on the defendants motion was held before the undersigned on June 24, 1991. Plaintiff was represented by Mark Streed, Esq. Defendants were represented by Assistant United States Attorney Lonnie Bryan, Esq.

I. FINDINGS OF FACT

Plaintiff has been in the custody of the Federal Bureau of Prisons since November of 1984, after being convicted of bank robbery. Prior to his incarceration plaintiff had undergone

FILED 05 SEP 1991
FRANCIS E. DOSAL, CLERK
JUDGEMENT ENTERED _____
DEPUTY CLERK'S INITIALS _____

several surgeries related to mouth cancer, including removal of squamous cell carcinoma. Plaintiff's treating physician, Dr. Randolph Howes, told plaintiff to keep a close watch for anything in his jaw resembling a thickening, a lump or a bump. In a letter dated March 15, 1985, Dr. Howes informed federal authorities that plaintiff suffered from "very aggressive squamous cell carcinoma" which he believed to be urgent and in need of evaluation and care.

In March 1985 plaintiff underwent "flap" surgery at the Federal Medical Center in Springfield to arrest his lip cancer. This surgery resulted in the removal of sections of plaintiff's lower lip, leaving him with a facial scar and a small mouth (microstomia). Physicians at FMC-Springfield noted that plaintiff should be seen at regular intervals for follow up subsequent to this surgery.

Plaintiff was transferred to the Federal Medical Center in Rochester, Minnesota (FMC-Rochester) in September 1985 for evaluation for reconstructive surgery to correct the microstomia and for observation for recurrence of his cancer. Plaintiff was housed in the general population at FMC-Rochester upon his arrival.

During his incarceration, plaintiff could--and did--report to sick call on several occasions to request medical treatment. Plaintiff acknowledged during his deposition that he was familiar with the sick call procedure and used it several times.

Upon his arrival at FMC-Rochester, medical director Dr. James Bastron referred plaintiff to Dr. Ian Jackson, a craniofacial neck surgeon at the Mayo Clinic. Plaintiff was seen by Dr. Jackson on

October 10, 1985. In a letter to Dr. Bastron, Dr. Jackson noted that plaintiff had no evidence of recurrent carcinoma, but had been told to "keep a close watch on his neck and facial area for any lumps and bumps." Dr. Jackson also opined that correction of the microstomia was not recommended. Dr. Jackson finally advised Dr. Bastron that it was important that plaintiff be kept under review and that he be examined in three months.

Plaintiff was again examined by Dr. Jackson on January 7, 1986, and Dr. Jackson again noted that there was no recurrence of the carcinoma, that corrective surgery on the microstomia was not recommended, and that plaintiff should be seen again in three months. The chart indicates that Dr. Bastron reviewed this notation on January 13, 1986.

On January 14, 1986 Warden Bogan notified the director of the Bureau of Prisons that plaintiff had been evaluated twice by Dr. Jackson, but that no recurrence of plaintiff's cancer had been found. Warden Bogan also noted that plaintiff had been requesting reconstructive surgery on his mouth, but that such surgery was not recommended by Dr. Jackson. Warden Bogan finally noted that plaintiff had impressed FMC-Rochester staff as "demanding and caustic", and that "he routinely threatens to pursue any action he views as unfavorable with litigation." Warden Bogan suggested that plaintiff be transferred to El Reno, Oklahoma at some point, but stated that further recommendation regarding transfer would be withheld until after plaintiff visited Dr. Jackson in April 1986.

On May 30, 1986 Dr. Jackson performed a follow up examination

of plaintiff, again noting that there was no recurrence of the carcinoma. At this time Dr. Jackson informed Dr. Bastron that plaintiff was unhappy with his treatment at FMC-Rochester and was concerned about his appearance, which Dr. Jackson found understandable considering the type of facial surgery plaintiff had undergone. Because plaintiff additionally suffered from a deep overbite (malocclusion), Dr. Jackson recommended that plaintiff be seen by an oral surgeon and orthodontist concerning both conditions. Dr. Jackson did not recommend another three-month follow up visit.

Notations in plaintiff's medical records indicate that Dr. Bastron discussed Dr. Jackson's recommendations with FMC-Rochester Warden Bogan on June 11, 1986. Upon notification from Warden Bogan, the medical director of the Bureau of Prisons recommended that further evaluation and, if necessary, treatment, be undertaken in accordance with Dr. Jackson's recommendations. A notation in plaintiff's medical records dated June 27, 1986 reveal that Dr. Bastron called Dr. Jackson's secretary, who was to "proceed with the necessary arrangements" for further evaluation.

During the Summer of 1986 plaintiff began complaining about a lump on his left jaw. On June 18, 1986 plaintiff's medical records reveal plaintiff's first complaint about a lump on his left mandible, which he reported as being related to a drill accident at work. No injury report was filed regarding this incident.

Plaintiff was subsequently referred to Dr. Teresa Jensen. Notes of Dr. Jensen's June 19, 1986 examination reveal that

plaintiff complained of a lump on his left mandible where he had been struck by a drill.

Dr. Jensen had x-rays taken which, when read at the Mayo Clinic, showed no evidence of bony lesions or other evidence of cancer. Plaintiff alleges that at this time he was informed that the lump was only "scar tissue", and was nothing to worry about.

Dr. Jensen next saw plaintiff on July 9, 1986. Her notes from this visit indicate that plaintiff's lump was a concern because of his past history, and she accordingly recommended that plaintiff be seen by Dr. Jackson.

Plaintiff was seen by Dr. Phillip Bernatz, a thoracic surgeon, on July 10, 1986 for an examination of "a nodule along the mandible". Dr. Bernatz' examination notes reveal that with plaintiff's history of cancer, "we cannot ignore this area." Upon examination, however, Dr. Bernatz was apparently of the opinion that the lump was flat and fixed, consistent with a history of trauma to that area. He also noted that the lump had decreased in size from that first reported to Dr. Jensen, and recommended that a "conservative approach was merited." Dr. Bernatz recommended, however, that plaintiff be seen by Dr. Jackson. The required "Request for Evaluation" by Dr. Jackson was apparently never completed because Dr. Bernatz was "new and not aware of all the coordinated activities."

Plaintiff was taken to the Mayo Clinic on July 24, 1986 but was not seen by Dr. Jackson, as had been recommended by Drs. Bastron, Bernatz and Jensen. Rather, plaintiff was seen by an oral

surgeon and orthodontist (Drs. Sather and Keller) for evaluation of his malocclusion.

Plaintiff stated during his deposition that he was performing "almost daily" examinations during this time. He further testified that he noticed that the lump was growing at the rate of about one centimeter (1/4 inch) per month. According to plaintiff, the lump was about the size of a jellybean by August 1986.

On September 9, 1986 plaintiff requested that he be seen by Dr. Bernatz. At that time, Dr. Bernatz made inquiries into plaintiff's July 24, 1986 consultation with the Mayo Clinic. On September 10, 1986 Dr. Bastron received a report of plaintiff's visit to the oral surgeon and orthodontist, which recommended extensive surgery to correct the malocclusion, and suggested that Dr. Jackson perform surgery to correct the microstomia. Plaintiff recalls that Dr. Bernatz told him during this visit that the lump was scar tissue, and that he need not worry about it.

Plaintiff stated during his deposition that he was, however, concerned about the lump at this time, and that "at every opportunity" he would ask the doctors and Warden Bogan if he could be referred to Dr. Jackson. Plaintiff maintains that he was always told not to worry, and that he would be "going downtown soon."

In a November 21, 1986 FMC letter to Robert Brutche, assistant director of the medical services division of the Bureau of Prisons, FMC-Rochester Warden Joseph Bogan stated that he had reviewed plaintiff's entire file, including his medical records, and concluded that medical treatment which had been proposed for

plaintiff's dental and orthodontic problems secondary to his previous surgeries was not indicated. Warden Bogan's letter further described plaintiff as "an angry, hostile young man who will continue to have serious behavioral and adjustment problems," and who has "constantly complained about his treatment since he has been incarcerated."

On December 1, 1986 plaintiff was cleared for transfer to a facility in El Reno, Oklahoma, which was closer to his home in Louisiana. Plaintiff's transfer order states that his medical treatment had been completed, and that his health status was "good." While en route to his eventual destination at El Reno, plaintiff was taken to FCI-Oxford and FCI-Terra Haute. On December 12, 1986, plaintiff told a physician's assistant at FCI-Terra Haute about a lump on his left jaw. According to an affidavit provided by the physician's assistant, plaintiff claimed to have noticed "within the last two months."

Plaintiff's medical records indicate that on January 15, 1987, he informed physicians at El Reno that his lump had been in existence since June 1986, and that "it should have been biopsied months ago". Plaintiff was eventually examined by an outside consultant, who recommended that a biopsy be performed on plaintiff's lump. The consultant informed Dr. Bastron of this recommendation, and plaintiff was returned to FMC-Rochester, where he was seen by Dr. Jackson on January 22, 1987.

On January 23, 1987 a biopsy was performed on the lump, which was found to be malignant. Dr. Jackson performed a radical

procedure immediately thereafter, which resulted in the removal of the plaintiff's left mandible, as well as a substantial amount of muscle and tissue in plaintiff's neck and shoulder. Dr. Jackson also found numerous other lumps during this surgery.

On October 19, 1989 plaintiff filed a claim against the United States, the Federal Bureau of Prisons, Warden Bogan and Drs. Bastron and Bernatz pursuant to the Federal Tort Claims Act (FTCA), 28 U.S.C. § 1346(b) and 28 U.S.C. § 2671, et seq. Defendants moved to have the FTCA claims dismissed as to all defendants except the United States and, in response, plaintiff moved to amend his complaint to assert Bivens-type claims against the individual defendants for their violations of the Eighth Amendment. See Bivens v. Six Unknown Agents of the Federal Bureau of Narcotics, 403 U.S. 388 (1971). On January 24, 1990 the court granted defendants' motion to dismiss, as well as plaintiff's motion to amend.

Count I of plaintiff's amended complaint charges the United States with negligence pursuant to the FTCA, and Count II charges the individual defendants with violations of the Eighth Amendment.

Defendants filed a motion to dismiss, or for summary judgment, as to Count II of plaintiff's complaint on various grounds including, inter alia, that plaintiff failed to sue the individual defendants in their individual capacity, that plaintiff impermissibly relied upon the doctrine of respondeat superior, and that defendants are protected by qualified immunity.

In an Order issued August 3, 1990, Judge MacLaughlin denied defendants motions. In his Order, Judge MacLaughlin specifically

found that defendants were not entitled to qualified immunity because there was a genuine issue of material fact with respect to whether defendants knew, or should have known, that their conduct violated plaintiff's constitutional right to medical treatment. Judge MacLaughlin also expressly found that the record contained sufficient evidence of each defendants' individual involvement with respect to plaintiff's medical care such that plaintiff did not improperly rely upon the doctrine of respondeat superior.

Defendants have now filed a motion to dismiss or, in the alternative, for summary judgment. Defendants allege that plaintiff's tort claim should be dismissed because it was filed after the expiration of the two year statute of limitations provided by the FTCA. Defendant further asserts that plaintiff's eighth amendment claims should be dismissed as to Warden Bogan because he is not a medical doctor and did not provide plaintiff with medical care or treatment, and that plaintiff's eighth amendment claims should be dismissed with respect to Drs. Bastron and Bernatz because there is no evidence on the record to show that they acted with deliberate indifference to plaintiff's medical needs. Finally, the individual defendants again assert that they are entitled to qualified immunity from plaintiff's constitutional claims.

II. DISCUSSION

A. Standard of Review: Motions for Summary Judgment

Defendants have moved for dismissal of plaintiff's claims

under Rule 12(b), Fed. R. Civ. P., and have alternatively moved for summary judgment in accordance with Rule 56. Because defendants have submitted materials outside of the pleadings in support of their motion, it will be treated as one for summary judgment.

The purpose of summary judgment is to pierce the pleadings and determine whether there actually is a basis for proceeding to trial. C. Wright & A. Miller, Federal Practice and Procedure §2739. The moving party bears the initial responsibility of stating the basis of its motion, and identifying those portions of "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, which demonstrate the lack of a genuine issue of material fact." Fed. R. Civ. P. 56(c); Celotex Corp. v. Catratt, 477 U.S. 317 (1986); Anderson v. Liberty Lobby, Inc., 477 U.S. 242 (1986); Matsushita Electric Industrial Co. v. Zenith Radio Corp., 475 U.S. 574 (1986). These opinions make it clear that when there is no reasonable construction of the facts that would allow the non-moving party to prevail, the remedy of summary judgment is appropriate. Matsushita, 475 U.S. at 587-88. Claims cannot survive a motion for summary judgment unless the responding party can, in some manner, set forth specific facts demonstrating that there is a genuine issue for trial. Quam v. Minnehaha County Jail, 821 F.2d 522 (8th Cir. 1987); Miller v. Solem, 728 F.2d 1020, 1023 (8th Cir.), cert. denied, 469 U.S. 841 (1984). Summary judgment will not lie where there are genuine factual issues that "properly can be resolved only by a finder of fact because they may reasonably be resolved in

favor of either party." Anderson, 477 U.S. at 250.

B. FTCA Claims

The FTCA is a limited waiver of sovereign immunity which subjects the federal government to liability for certain torts committed by federal employees acting within the scope of their employment. 28 U.S.C. § 2671 - 2680; United States v. Orleans, 425 U.S. 807, 813 (1976). As a limited waiver of sovereign immunity, the terms of the FTCA must be strictly construed. See Honda v. Clark, 386 U.S. 484, 501 (1967).

Section 2401(b) of Title 28 provides that:

A tort claim against the United States shall be forever barred unless it is presented in writing to the appropriate Federal agency within two years after such claim accrues or unless the action is begun within six months after the date of mailing, by certified or registered mail, or notice of final denial of the claim by the agency to which it was presented.

Failure to file within the time allowed by this section is a jurisdictional defect. Landreth v. United States, 850 F.2d 532, 533 (9th Cir. 1988) (citations omitted). Further, the Supreme Court has instructed the judiciary to abstain from extending or narrowing section 2401(b) beyond the express terms set by Congress, thereby defeating its obvious purpose. United States v. Kubrick, 444 U.S. 111 (1979).

A claim "accrues" within the meaning of section 2401(b) when the plaintiff knows, or in the exercise of due diligence should have known, both the existence of and the cause of his injury. Kubrick, 444 U.S. at 111; see also Gould v. U.S. Dept. of Health

and Human Svcs., 905 F.2d 738, 742 (4th Cir. 1990); Landreth, 850 F.2d at 533. Medical malpractice claims under the FTCA accrue when a plaintiff has discovered his injury and its probable cause, even though he may be ignorant of his legal rights. Kubrick, 444 U.S. at 111. The statute of limitations does not await the plaintiff's knowledge that his injury was caused by negligence or reckless conduct. Id. at 122-24.

In determining the accrual date of medical malpractice claims based upon the failure to diagnose or to treat a preexisting condition, the Ninth Circuit has held that the "injury" which triggers the two year period set forth in section 2401(b) is the development of the problem into a more serious condition which poses greater danger to the patient or which requires more extensive treatment. Augustine v. United States, 704 F.2d 1074, 1078 (9th Cir. 1983) (emphasis in original). Thus, it is only when the patient becomes aware, or through the exercise of reasonable diligence should have become aware, of the development of a pre-existing problem into a more serious condition that his cause of action can be said to have accrued for purposes of section 2401(b). Id.; accord Raddatz v. United States, 750 F.2d 791, 796 (9th Cir. 1984). Although the Eighth Circuit does not appear to have expressly adopted the test set forth in Augustine, the Eighth Circuit has found that the question of when a patient becomes aware of, or through the exercise of reasonable diligence should have become aware of, the deterioration of his or her condition or of the seriousness of the injury, is one of fact. Wehrman v. United

States, 830 F.2d 1480, 1484 (8th Cir. 1987) (citing Augustine, 704 F.2d at 1078-79).

In the instant matter, plaintiff filed his FTCA administrative claim alleging medical malpractice on October 28, 1988. Defendant believes that plaintiff's FTCA claim should be dismissed because it accrued prior to October 28, 1986.

Defendants assert that discovery exchanged in this case indicates that prior to October 1986, plaintiff knew that he had a cancerous condition that required observation, knew that he was to watch for suspicious lumps on his jaw, and knew the risks associated with untimely treatment. Defendants further state that the record shows that prior to October 1986 plaintiff had acquired and read medical books on his affliction, and knew about the "injuries occasioned by delayed biopsies".. Finally, defendant knew that he needed to be examined by Dr. Jackson and that defendants' referrals failed to result in plaintiff being so examined.

In light of the foregoing, defendants assert that as early as June 1986, plaintiff possessed enough information to be suspicious about whether the FMC physicians had properly treated his condition. See Drazan v. United States, 762 F.2d 56, 59 (7th Cir. 1985) ("It [the statute of limitations] begins to run either when the government cause is known or when a reasonably diligent person (in the tort claimant's position) reacting to any suspicious circumstances of which he might have been aware would have discovered the government cause--whichever comes first"). Defendants further argue that plaintiff's claim likely accrued when

he realized that Drs. Bastron and Bernatz had failed to get him an appointment with Dr. Jackson. Defendants therefore believe plaintiff's cause of action accrued as early as June 1986, and it may have arisen at some point in late July or August 1986 when it became apparent that he was not going to be seen by Dr. Jackson.

The undersigned finds this argument unpersuasive. Plaintiff's first complaint of a lump was reported to Dr. Jensen in June 1986. Despite defendants' belief that plaintiff was well educated in the significance of finding lumps or thickenings in his jaw area, plaintiff reported to Dr. Jensen that he thought the lump may have been caused by coming into contact with a drill he used during work at the prison. While it is true that Dr. Jensen was concerned enough about the lump to refer plaintiff to Dr. Jackson, further examination by Dr. Bernatz indicated that the lump was "flat and fixed, consistent with a history of trauma to that area". Dr. Bernatz also noted at that time that the lump had decreased in size from that first reported to Dr. Jensen. Thus, the only physicians available to plaintiff throughout the summer of 1986 assured plaintiff that the lump was of no concern.

The record further indicates that Dr. Jackson had not noticed any lump when he examined plaintiff on May 30, 1986. At that time, Dr. Jackson recommended that plaintiff be seen by an orthodontist and an oral surgeon, and plaintiff was, in fact, seen by these two specialists---at Dr. Jackson's referral and request---in July 1986. Consequently, the undersigned finds that defendants' failure to ensure that plaintiff was seen by Dr. Jackson during the Summer of

1986 cannot be construed as an event which should have compelled the plaintiff to suspect that the defendants were acting negligently.

The facts in the instant case are similar to those faced by the Ninth Circuit in Raddatz, supra. In that case, a plaintiff sued her Navy doctor for malpractice because of his failure to diagnose and inform her of a uterine infection resulting from an Army doctor's perforation of her uterus. The Army doctor had inserted an IUD into plaintiff, but removed it immediately after it became clear that he had injured her by his placement of the IUD. Thereafter, the Navy doctor assured plaintiff that her cramps, discomfort, and severe pain were normal side effects of perforation of the uterus. Upon examination by a private physician, however, plaintiff ultimately discovered that she was suffering from pelvic inflammatory disease, which necessitated that she undergo a hysterectomy. The Ninth Circuit held that plaintiff's claim "accrued" for purposes of the FTCA not when the Navy doctor failed to diagnose her condition properly, but when the private physician had made her aware that her perforated uterus had developed an infection which could have been treated earlier with antibiotics. Raddatz, 750 F.2d at 793-94, 796; see also Rosales v. United States, 824 F.2d 799, 804-05 (9th Cir. 1987) (injury accrued on date when parents discovered fact of injury previously misdiagnosed by government doctors); Nicolazzo v. United States, 786 F.2d 454, 456 (1st Cir 1986) (injury accrues for purposes of FTCA when plaintiff receives final, correct diagnosis which enables him to be "in

possession of the critical facts" that he has been injured and that certain persons have likely inflicted the injury).

Defendants rely upon the Seventh Circuit's decision in Green v. United States, 765 F.2d 105 (7th Cir. 1985), for the proposition that despite the assurances from the FMC doctors, plaintiff was armed with enough facts such that he must have known the nature and extent of his injuries long before January 1987. The undersigned finds defendants' reliance on Green to be misplaced.

The court in Green relied upon the proposition that "once a plaintiff is armed with the facts about the harm done to him, he can protect himself by seeking advice in the medical and legal community." 765 F.2d at 108 (emphasis added) (citing Kubrick, 444 U.S. at 123); accord Sexton v. United States, 832 F.2d 629, 633 (D.C. Cir. 1987) (once plaintiff is possessed of critical facts, "he need undertake only a reasonably diligent investigation to determine whether a cause of action may lie").

Even if plaintiff did suspect--or should have suspected--that the diagnoses of the FMC physicians were wrong, however, it is difficult to imagine how plaintiff, as an incarcerated person, could have obtained "second opinions" from the private medical community to determine whether he was being properly treated during the summer of 1986. The undersigned concludes that plaintiff's cause of action did not accrue prior to October 1986. Defendant's summary judgment motion on statute of limitations grounds should be denied.

C. Constitutional Claim

1. Failure to State Eighth Amendment Claim

The language of the Eighth Amendment, "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted," manifests "an intention to limit the power of those entrusted with the criminal-law function of government." Whitley v. Albers, 475 U.S. 312, 318 (1986), citing Ingraham v. Wright, 430 U.S. 651, 664 (1977). The Supreme Court has stated that inadequate health care rises to a constitutional violation only when prison officials are deliberately indifferent to a serious medical need. Estelle v. Gamble, 429 U.S. 97, 104 (1976); Lair v. Ogelesby, 859 F.2d 605, 606 (8th Cir. 1988).¹

The Estelle standard of deliberate indifference is violated in situations of "continued and unnecessary pain." See Roswell v. Sherburne County, 849 F.2d 1117, 1122 (8th Cir. 1988). Negligence in diagnosis or treatment of a medical condition is not actionable in a civil rights claim, Estelle, 429 U.S. at 106; nor is a mere disagreement with the course of treatment. Taylor v. Turner, 884 F.2d 1088, 1090 (8th Cir. 1989); Lair, 859 F.2d at 606; Ellis v. Butler, 890 F.2d 1001, 1003 (8th Cir. 1989). It is "obduracy and wantonness", not inadvertence or error in good faith, that characterize the conduct prohibited by the Eighth Amendment. Whitley, 475 U.S. at 319; Givens v. Jones, 900 F.2d 1229, 1232

¹ Counsel for defendants has called the court's attention to the Supreme Court's recent decision in Wilson v. Seiter, 59 U.S.L.W. 4671 (1991), in which the Court extends the Estelle deliberate indifference standard to cases where prisoners assert conditions of confinement claims against prison officials. The undersigned finds that the Wilson case has no bearing on the outcome of the defendants' instant summary judgment motion.

(8th Cir. 1990).

Defendants claim that plaintiff has--at best--asserted a medical malpractice claim based upon defendants' alleged negligence in not ordering certain tests (such as performing a biopsy on the lump), and/or in not providing him with proper treatment in the form of referrals to Dr. Jackson. Defendants' argue that their diagnoses and methods of treatment raise questions of medical judgment which do not amount to deliberate indifference. See White v. Farrier, 849 F.2d 322, 327 (8th Cir. 1987); Noll v. Petrovsky, 828 F.2d 461, 462 (8th Cir. 1987), cert. denied, ___ U.S. ___, 108 S.Ct. 718 (1988).

The undersigned finds that plaintiff's eighth amendment claims in the instant matter go beyond mere disagreement with the defendants' course of action. Rather, plaintiff's claims are based upon his belief that defendants failed to heed the fact that he had a significant--and well documented--history of cancer which required close monitoring and attention. Delay in providing medical care which ultimately resulted in "continued and unnecessary pain" has been found to violate the deliberate indifference standard of Estelle. See Boswell, supra, 849 F.2d at 1120 (citing Ramos v. Lamm, 639 F.2d 559, 576 (10th Cir. 1980), cert. denied, 450 U.S. 1041 (1981); Herrera v. Balentine, 653 F.2d 1220 (8th Cir. 1981)).

The record shows that the defendant physicians, keeping in mind the importance of monitoring any lumps or growths on plaintiff's jaw, had recommended that plaintiff be seen by Dr.

Jackson after plaintiff first discovered a lump in his jaw in June 1986. The record does not indicate any followup by either physician, however, to ensure that plaintiff did, in fact, see Dr. Jackson. The record shows only that plaintiff was seen by an orthodontist and oral surgeon, at the recommendation of Dr. Jackson, to correct his overbite. There is no indication that Dr. Jackson himself ever actually examined plaintiff after the lump had been discovered in June 1986.

Plaintiff further claims that the defendant physicians failed to treat the growing lump on his jaw despite his complaints to the contrary. Defendants state that plaintiff's medical record does not document such complaints. Defendants argue that plaintiff was well-versed in the procedures required for sick call visits, and that he used sick call more than 15 times during the summer of 1986. None of these reports reflect plaintiff's concern about the lump. Defendants argue that the absence of notations in plaintiff's sick call records suggests that plaintiff did not make complaints regarding the lump during the period in question.

Defendants further assert that the report of Drs. Keller and Sather, the orthodontist and oral surgeon, is also silent on the existence or nature of the lump on plaintiff's jaw. Defendants have stated that they "assumed" that Drs. Keller and Sather had properly evaluated the lump on plaintiff's jaw, and assumed that the lack of mention of the lump in their report suggests that it was concluded that the lump was of no significance.

Plaintiff has asserted in his deposition that he told the

defendants about his concerns regarding the lump on numerous occasions, but received no attention or care. Although defendant Dr. Bernatz has stated that he would have given plaintiff another referral to Dr. Jackson had he known of plaintiff's concern about the lump in September 1986, a September 26, 1986 notation by unit manager Teresa Hunt indicating "no special concerns regarding new lump per Dr. Bernatz" suggests that Dr. Bernatz was, in fact, aware of plaintiff's concern during the period in question. The record further shows that Hunt testified during her deposition that plaintiff had expressed concern to her about the lump on several occasions, and that such concerns would not normally have been documented.

In light of the foregoing, the undersigned finds that there is a genuine issue of material fact with respect to plaintiff's eighth amendment claims regarding his treatment--or lack thereof--at the hands of defendants. Consequently, it will be recommended that defendants' motion for summary judgment be denied on these grounds.

2. Lack of Personal Involvement

A civil rights action cannot be based upon the theory of respondeat superior. Monell v. Department of Social Services, 436 U.S. 658, 694 (1978). A plaintiff must make a showing that the supervisory official had direct responsibility for the improper conduct alleged in the complaint. See Rizzo v. Goode, 423 U.S. 362 (1976). Liability will therefore only be found if there is personal involvement on the part of the supervisory official.

Harris v. Pirch, 677 F.2d 681, 685 (8th Cir. 1982), accord Rasmussen v. Larson, 863 F.2d 603, 605 (8th Cir. 1988); Wilson v. City of North Little Rock, 801 F.2d 316, 322 (8th Cir. 1986).

Defendant Warden Bogan argues that he cannot be held responsible for medical judgments concerning plaintiff's treatment because he is not a medical doctor and because he relied upon the diagnosis and recommendations of medical professionals to make his administrative decisions.² See Crooks v. Nix, 872 F.2d 800, 803 (8th Cir. 1989). The undersigned agrees that Warden Bogan is not a medical doctor and, as such, cannot be held responsible for making diagnoses and treatment decisions. Nevertheless, the undersigned finds that Bogan had the responsibility to review the recommendations of the medical professionals under his supervision and combine these with general prison administrative policies to make an ultimate decision regarding whether certain treatment was warranted and whether plaintiff was healthy enough to be transferred to another institution.

Warden Bogan made such decisions when he reviewed plaintiff's medical records and recommended to the assistant director of the medical services division of the Bureau of Prisons that proposed medical treatment for plaintiff not be provided. An examination of that recommendation indicates that Warden Bogan placed a great deal

² In their previous summary judgment motion heard before Judge MacLaughlin, defendants argued that plaintiff failed to show that each defendant's actions amounted to a deliberate and willful indifference to his medical needs. Judge MacLaughlin found that there was a genuine issue of material fact with respect to the specific involvement of each individual defendant, and therefore denied summary judgment.

of emphasis on plaintiff's "difficult" personality. Consequently, the undersigned finds that Warden Bogan had sufficient involvement in the actions which give rise to plaintiff's claims to make him potentially liable for plaintiff's Rivens claim. See Miltier v. Beorn, 896 F.2d 848, 854 (4th Cir. 1990) (supervisory liability not based upon respondeat superior, but upon recognition that "supervisory indifference or tacit authorization of subordinate misconduct" may be direct cause of constitutional injury); Howell v. Evans, 922 F.2d 712, 723 (11th Cir. 1991) (fact that warden had policy to rely solely upon recommendations made by medical personnel does not lessen his duties--"an official does not insulate his potential liability for deliberately indifferent actions by instituting a policy of indifference"). The court concludes that plaintiff's claims against Warden Bogan are not based upon Respondeat Superior, but upon plaintiff's allegation that Warden Bogan was personally involved in the decisions respecting plaintiff's care and treatment. The court further concludes there is a genuine issue of material fact as to whether he was deliberately indifferent. It will therefore be recommended that Warden Bogan's motion for summary judgment, based upon his lack of involvement, be denied.

3. Qualified Immunity

Federal officials are entitled to qualified immunity for suits brought against them under the Constitution. Butz v. Economou, 438 U.S. 478 (1978). In Brown v. Fey, 889 F.2d 159 (8th Cir. 1989), cert. denied, 110 S.Ct. 1156 (1990), the Eighth Circuit held that

prison officials are entitled to immunity from constitutional claims unless: 1) their conduct violated a constitutional right of the plaintiff that was clearly established prior to the time of the alleged acts of the prison officials; 2) they knew or should have known of the clearly established right; and 4) they knew or should have known that their conduct violated that right.

889 F.2d at 165 (citations omitted).

Defendants assert that the constitutional right plaintiff claims they have violated (the right to be free of deliberate indifference to his medical needs) was not clearly established at the time in question. Defendants additionally assert that plaintiff has not--and cannot--show that their actions (or inactions, as the case may be) amount to deliberate indifference.

a. Clearly Established Constitutional Right

Defendants contend that in 1986, when the alleged acts and omissions giving rise to plaintiff's claim occurred, the constitutional standard with respect to the provision of the specific medical care required by plaintiff was not "clearly established".³ Although defendants appear to concede that the general Estelle "deliberate indifference" standard was clearly established in 1986, they contend that in cases where eighth amendment claims are based on medical treatment, "[t]he specificity of the standard is particularly important . . . because the mere negligent diagnosis or treatment of a patient does not constitute

³ Defendants did not assert this argument in their previous motion for summary judgment on the defense of qualified immunity.

deliberate indifference." See Howell, supra, 922 F.2d at 719.

The undersigned finds that at the time the plaintiff was being treated in the summer of 1986, the law governing the defendants' conduct was clearly established. The Supreme Court, ten years earlier, in Estelle, supra recognized a distinction between negligence and deliberate indifference: An alleged error in medical judgment amounts to negligence, while deliberate indifference is manifested by a refusal to act when certain actions were or should have been known to be necessary. 429 U.S. at 104-05. Thus, if an official knows or should know that certain treatment is necessary and he delays in providing such treatment when he reasonably should know that such delay can be hazardous, his actions could constitute deliberate indifference. Id.; accord Johnson v. Hay, 931 F.2d 456, 461 (8th Cir. 1991); see also Cummings v. Roberts, 628 F.2d 1065, 1067-68 (8th Cir. 1980) (defendants not entitled to summary judgment on prisoner's eighth amendment claim based on allegations that defendants deliberately denied access to medical care and failed to carry out prescribed treatment).

There is no dispute that a government official cannot be held liable for the violation of "extremely abstract rights". Anderson v. Creighton, 483 U.S. 635, 639 (1987); Givens v. Jones, 900 F.2d 1229, 1232 (8th Cir. 1990). This does not mean, however, that "an official action is protected by qualified immunity unless the very action in question has been held unlawful." Id. at 640; Coffman v. Trickey, 884 F.2d 1057, 1063 (8th Cir. 1989) ("It is not necessary

that [the official's] action has been previously held unlawful, but only that, in view of pre-existing law, the unlawfulness of [the official's] act is apparent"), cert. denied, ___ U.S. ___, 110 S.Ct. 1523 (1990).

Defendants assert that in 1986, it was not clearly established that "making a treatment decision over plaintiff's objection and causing injury" violated a constitutional right. The undersigned finds that in making this argument defendants fail to focus on the exact nature of plaintiff's claims. Plaintiff claims in his amended complaint that at the time he was transferred to FMC Rochester defendants knew that he had a volatile cancerous condition which required close monitoring, but that they failed to heed the request to closely watch plaintiff's condition, failed to respond to plaintiff's repeated requests for treatment of the growing lump, and failed to ensure that he be examined by Dr. Jackson. There is no suggestion in the record that plaintiff's claims arose because of a disagreement regarding treatment actually provided by the defendant doctors.

The undersigned finds that plaintiff's right to treatment for and monitoring of his well-known cancerous condition was clearly established at the time at issue in this suit, and that the defendants knew--or should have known--of this right. Further, in denying defendants' first summary judgment motion, Judge MacLaughlin expressly found as follows:

Here, there is no question that the applicable legal standard was clearly established at the time alleged in plaintiff's complaint. In Estelle v. Gamble, 429 U.S. 97 (1976), the court held that "deliberate indifference to

serious medical needs of prisoners" violates the eighth amendment. Id. at 104. The Court held that such indifference can be manifested by:

prison doctors in their response to the prisoners' needs, or prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed.

Id. at 104-05. In Carlson v. Green, 446 U.S. 14 (1980), the United States Supreme Court held that the standards articulated in Estelle v. Gamble applied in a Bivens cause of action against federal defendants. Both of the seminal cases articulating the applicable legal standard predated the conduct in question in this case.

August 2, 1990 Order, pgs. 11-12.

In light of established case law, and in consideration of Judge MacLaughlin's previous order, the undersigned finds that plaintiff's constitutional right was clearly established at the time during which the plaintiff's claims arose, and that the defendants knew or should have known of this right. Defendants are not entitled to qualified immunity based upon this argument.

b. Deliberate Indifference

Defendants also assert that plaintiff has failed to show that they knew, or should have known, that their actions amounted to deliberate indifference to plaintiff's medical needs. Although Judge MacLaughlin denied their first motion for summary judgment on the grounds that a genuine issue of fact existed with respect to whether they knew or should have known that their conduct violated the deliberate indifference standard, defendants now believe that enough information has been exchanged through discovery to date to indicate that they, at most, acted negligently.

As noted by Judge MacLaughlin in his previous order, qualified

immunity is an affirmative defense, for which the burden of pleading and proof rests with the defendant. Gomez v. Toledo, 100 S.Ct. 1920, 1924 (1980). The test for qualified immunity at the summary judgment stage is an objective one. Anderson v. Creighton, 483 U.S. 635 (1987). In order to determine whether prison officials are protected by qualified immunity, the court must decide "the essentially legal question whether the conduct of which [plaintiff] complains violated clearly established law," and if plaintiff's complaint adequately alleges commission of such acts. Mitchell v. Forsyth, 472 U.S. 511, 526 (1985), as cited in Johnson, supra, 931 F.2d at 460. The defendants are entitled to summary judgment if discovery has failed to uncover evidence sufficient to create a genuine issue as to whether their conduct violated clearly established law. Id.

Defendants believe that the record shows that they did not act with deliberate indifference to plaintiff's medical needs. They note that while plaintiff was at FMC Rochester he had a large number of complaints, and had a demonstrated familiarity with the institution's sick call practices. None of plaintiff's BP-9's (prisoner complaints) or his sick call records show, however, that he complained about a growing lump during the period in question. Defendants state that had such references appeared in these documents, plaintiff would have been treated accordingly.

Defendants also rely heavily on the July 24, 1986 report of Drs. Keller and Sather, the orthodontist and oral surgeon who examined plaintiff for his overbite. This report contains no

reference to the lump, or to the possibility that plaintiff's cancer had recurred. Defendants state that because Dr. Keller has written and published articles on the examination of a mandible for cancerous growth, they reasonably relied upon the absence of a reference to a possible recurrence of cancer in the July 24, 1986 report.

They find significant the fact that as of May 30, 1986 Dr. Jackson had found no lump or evidence of recurrence, and as of July 1986, fifteen months had passed since plaintiff's last recurrence. Defendants note that Dr. Jackson testified that as time passes, the chance for recurrence subsides. Further, defendants note that records of an examination of plaintiff performed by Mayo Clinic physicians in October 1986 were silent with regard to any complaints about a lump, as were the notes of plaintiff's visits to a physician's assistant in early November 1986.

Finally, defendants believe that plaintiff had seen Dr. Jackson in accordance with their referrals. They believed that Dr. Jackson's involvement was evidenced by the fact that he had referred plaintiff to Drs. Sather and Keller, and by the fact that Sather and Keller's recommendation referred to procedures to be performed by Dr. Jackson.

With respect to defendant Bogan, defendants assert that the memoranda indicating no recurrence, the absence of notations in sick call records regarding a growing lump, and the opinions of defendant Dr. Bastron justified defendant Bogan's recommendations that plaintiff not undergo certain procedures, and that he be

declared physically eligible for transfer to another institution.

Defendants' argue that a physician "need not necessarily accept as true the medical judgments offered by his patients", Givens, 900 F.2d at 1232, and that eighth amendment violations cannot be based on mere disagreements with medical treatment, Lair, 859 F.2d 605. While the undersigned agrees with this general statement of existing eighth circuit law, the undersigned finds that plaintiff's claims in the instant matter do not deal with disagreements regarding medical treatment or a refusal to treat plaintiff with a certain method, procedure or drug. Rather, plaintiff claims that defendants failed to attend to a cancerous condition which they knew required observation and attention. In light of these claims, the undersigned finds that there exists in the a genuine issue of material fact as to whether defendants failed to follow through on their obligations with respect to plaintiff's condition, and whether the defendants acted with deliberate disregard.

The undersigned's review of the record indicates that defendants were aware of the significance of plaintiff's condition, and that they knew that plaintiff's mouth and jaw area was to be watched closely. With respect to defendant Dr. Bernatz, the record shows that he saw plaintiff in early July 1986 regarding the lump. His notes of this visit indicate that "with [plaintiff's] history we cannot ignore the area . . . for this inmate the pressure to know 'now' is great and we can understand why with his history." Thus, although Dr. Bernatz assured plaintiff that the lump was

likely just scar tissue, he had recognized that the lump required serious attention and follow up, and referred plaintiff for an examination by Dr. Jackson. Despite this knowledge and concern, the record shows that Dr. Bernatz did not follow up on plaintiff's referral. Rather, as he testified at his deposition, he "assumed" that Dr. Jackson had examined plaintiff.

At plaintiff's insistence, Dr. Bernatz again saw plaintiff in early September 1986. It was at this time Dr. Bernatz reviewed the report of Drs. Keller and Sather, and apparently concluded that the absence of a reference to either the lump or to the recurrence of cancer indicated that a proper examination of plaintiff's mandible had been performed, and that plaintiff had no significant condition requiring immediate attention. Although Dr. Bernatz testified at his deposition that he would have referred the plaintiff back to the Mayo clinic had he known of plaintiff's concern about the lump, notes taken in late September 1986 by plaintiff's unit manager, Teresa Hunt, indicate that she was told by Dr. Bernatz that there were "no special concerns regarding new lump". Finally, Dr. Bernatz testified that he had had additional contact with plaintiff at FMC, that plaintiff was "always concerned" about his medical condition, and that he would ask "anybody he would encounter" about his treatment. He finally testified that plaintiff's concern about his condition was "justifiable."

With respect to defendant Dr. Bastron, the record indicates that he had referred plaintiff to Dr. Jackson on several occasions immediately after plaintiff's arrival at FMC, and that he was the

recipient of the reports from Dr. Jackson indicating that plaintiff's condition needed to be closely watched. Dr. Bastron again referred plaintiff to Dr. Jackson in late June 1986 and, although he never received a specific examination report from Dr. Jackson similar to the ones he had previously received, he testified at his deposition that he assumed that plaintiff had seen Dr. Jackson in accordance with his June referral. Dr. Bastron further testified that he assumed Drs. Sather and Keller had conducted an examination of plaintiff's mandible at the time they performed their orthodontic examination in late July 1986. Dr. Bastron testified that he never spoke to either Dr. Keller or Dr. Sather to confirm this conclusion.

With respect to Warden Bogan, the record shows that he was integrally involved in making decisions regarding plaintiff's eligibility for transfer, which were to be based on his medical condition. Warden Bogan informed the Bureau of Prisons in January 1986 that plaintiff's potential treatment and reconstructive surgery was being evaluated by Dr. Jackson, and that recommendations regarding plaintiff's transfer to another institution would be withheld until further evaluation had been performed by Dr. Jackson. The Warden's January communication further noted that plaintiff was "demanding and caustic", and appeared to be quite litigious.

Plaintiff's difficult personality was also stressed in the Warden's November 1986 memorandum to the Bureau of Prisons, which contained a recommendation that plaintiff not be provided with

reconstructive surgery, and which recommended that plaintiff be transferred. In his deposition, Warden Bogan acknowledged that when making his decisions he did not review many of the handwritten documents in plaintiff's file because they were difficult to read and because he didn't think there was anything in them that would be germane to his recommendations. An examination of the record indicates that Warden Bogan had available to him at that time a handwritten memorandum dated late September 1986 to Warden Bogan from unit manager Hunt which referenced plaintiff's lump.

The record shows that each of the defendants were aware of plaintiff's serious medical condition. The record is replete with the defendant doctors' assumptions regarding plaintiff's treatment and examination by Dr. Jackson, and assumptions regarding the lack of references to the lump in reports and medical notes. The record also shows that defendant Warden Bogan's recommendations to the Bureau of Prisons were based upon his assumption that handwritten documents in plaintiff's file would not be germane to his decisions, and based upon his conclusion that plaintiff was demanding, caustic, hostile and litigious. Warden Bogan's assertion that he merely relied upon the recommendations of the medical staff cannot insulate him from responsibility. See Miltier, supra; Howell, supra.


The undersigned finds it improbable that a valid qualified immunity defense could be grounded upon evidence that defendants "assumed" that certain material activities had been performed by others, or that certain material evidence could be disregarded in

making critical decisions because it was hard to read, or because it was "unlikely to be germane". Consequently, the undersigned will recommend that the defendants' motion for summary judgment on their qualified immunity defense be denied.

Accordingly, based upon the foregoing and all of the files, records and proceedings herein,

IT IS HEREBY RECOMMENDED that defendants' motion for summary judgment be DENIED, in its entirety.

DATED: Sept 5, 1991


 FRANKLIN L. NOEL
 United States Magistrate Judge

Pursuant to Local Rule 72.1(c)(2), any party may object to this report and recommendation by filing with the Clerk of Court and serving all parties, within ten days after being served with a copy thereof, written objections which specifically identify the portions of the proposed findings, recommendations or report to which objection is being made, and a brief in support thereof. A party may respond to the objecting party's brief within ten days after service thereof. All briefs filed under this rule shall be limited to ten pages. A judge shall make a de novo determination of those portions to which objection is made.

APPENDIX 5.—LETTER FROM RONALD L. KUBY, ESQ., LAW OFFICE OF
WILLIAM M. KUNSTLER (TRANSMITTING STATEMENT OF DR. ALAN
BERKMAN), TO ELIZABETH FINE, ASSISTANT COUNSEL, JULY 17,
1991

Law Office of
William M. Kunstler

13 Gay Street
New York, N.Y. 10014
(212) 924-5661
Fax (212) 691-3204

William M. Kunstler
Ronald L. Kuby

Staff
Mahtowin
Rosa Maria de la Torre
Cervielle Gemma

Subcommittee on Intellectual Property
And Judicial Administration
William J. Hughes, Chairman
U.S. House of Representatives
207 Cannon House Office Building
Washington, D.C. 20515

Attn: Elizabeth Fine

Via: Federal Express

July 17, 1991

Re: Dr. Alan Berkman

Dear Ms. Fine:

I am pleased to transmit one original of the statement of Dr. Alan Berkman to the Subcommittee. Please contact me if you have any questions regarding this matter.

Sincerely,



Ronald L. Kuby

STATEMENT OF DR. ALAN BERKMAN

My name is Dr. Alan Berkman. I appreciate this opportunity to submit a statement to the Subcommittee. The Bureau of Prisons (BOP) has direct responsibility for the health of some 60,000 prisoners on any single day, and from my own experience and observations, significant improvements in health care need to be made in order to bring the standard of care to an acceptable and humane level. I have also noticed over the years that the philosophy and practices of the BOP influence the operations of state prisons, institutions now holding approximately one million Americans. I hope that any positive developments in BOP health care that are implemented as a result of these hearings will be emulated by the state prison systems.

Personal Background

I have been a prisoner for more than six years. I am serving a twelve-year federal sentence for politically-motivated criminal acts and have one more year to serve. As will become clear from my medical history, I have spent much of that time outside of federal institutions in the custody of the U.S. Marshals' Service. I have, however, been at the U.S. Medical Center for Federal Prisoners at Springfield, at the Federal Medical Center at Rochester, and at U.S.P. Marion.

I am a physician. I was a National Merit Scholar and a graduate of Cornell University and Columbia College of Physicians and Surgeons. I

trained in Internal Medicine at Presbyterian Hospital in New York City. I practiced primary care medicine for ten years, primarily in poor and medically under-served communities in New York City. I was on the staff of several hospitals.

I have also been interested in prison health for many years, long before my own incarceration. In the fall of 1971, the Attica Rebellion occurred. I was asked by the Fortune Society to examine and evaluate prisoners who had been injured at Attica and were subsequently transferred to segregation units all over the state. The human misery and poor medical care I witnessed had a great impact on me, and at the end of that year of training, I left academic medicine and took a job as a prison doctor at the Bronx House of Detention. I was there in 1972-73. Even after I left, I remained active in prison health issues and consulted on cases in both the state and federal system.

Medical History

I was in good health with no significant medical history at the time of my May, 1985 arrest by the FBI. I was arrested outside of Philadelphia, which had no federal detention center. I was therefore housed by the U.S. Marshal in the segregation unit of Harrisburg Prison. In June 1985, I suffered a complete tear of my left Achilles tendon, causing immediate pain and inability to walk. Because of my own medical experience, I knew the nature of my injury. After a delay of several hours, I was taken to the Emergency

Room of a small hospital. The U.S. Marshals cleared the area of all patients in a manner that intimidated both patients and staff. The examining physician, clearly upset by the security measures, misdiagnosed the injury, labelling it a minor muscle pull despite my objections. I was given no treatment.

The pain, swelling, and disability persisted, and every day I demanded to see a specialist. After two weeks, I was taken to see the prison orthopedist, who immediately diagnosed a torn tendon. It was now too late for a direct surgical repair, but he recommended, and I agreed to, a tendon transplant. The surgery was to be the next week.

On the day I was to be admitted to the secure prison ward of a major Philadelphia hospital, the U.S. Marshals instead drove me 4 hours to the U.S. Penitentiary at Lewisburg, Pennsylvania. No one was notified of my transfer, and it was not discovered until my wife, Barbara Zeller, also a doctor of medicine, tried to visit me at the hospital and was told I was not there.

I was placed in 24-hour lockup in a psychiatric observation cell at Lewisburg, and was denied all contact with other prisoners or access to the telephone.

After two days I was seen by the prison doctor, a general practitioner with no training in orthopedics. He told me that the U.S. Marshals had decided that I could not go to a hospital for the indicated surgery. When I objected, he called a local orthopedist on the telephone to

discuss my case. That physician also stated that a tendon graft was indicated. That advice was also ignored. Instead, the prison doctor placed a non-ambulatory cast on my leg.

My lawyer eventually succeeded in having me returned to Philadelphia. At a court hearing, the trial judge officially rebuked the U.S. Attorney's Office, the U.S. Marshal's Service, and the Bureau of Prisons, describing my treatment as unwarranted, inhuman, and unconscionable.

The tendon did not heal well and the cast had to remain on for 24 weeks. I have residual disability and a limp.

Hodgkin's Disease

I initially noted enlarged lymph nodes under my right arm in October 1965 and brought them to the attention of the prison doctor. He had difficulty verifying my findings, but at my insistence, I was seen by a surgeon who recommended a lymph node biopsy. This took place in a local hospital in early November under extreme security precautions that included armed Marshals inside and outside the operating room. The biopsy showed Hodgkin's Disease, a type of cancer.

Even after the diagnosis, it took more than a month for me to have the required preliminary tests and X-rays because of the security measures imposed by the U.S. Marshals. When preliminary tests showed that abdominal surgery was indicated, the government tried to have me moved to the U.S. Medical Center for Federal Prisoners in Springfield, Missouri. We

demanded a hearing before the trial judge and offered expert testimony, including that of the civilian cancer specialist hired by the government, to show that Springfield was not qualified to treat Hodgkin's Disease and that such a transfer would significantly decrease my chances of survival. The government initially persisted in the face of this testimony, but when the judge made it clear that he would rule in my favor, they agreed to have me treated at an appropriate cancer center.

I underwent a staging laparotomy and splenectomy on December 13, 1965, again with armed Marshals inside and outside the operating room. Post-operatively, I developed a fever, a pleural effusion, and had difficulty eating. Despite these problems I was discharged on December 20, 1965 with an intravenous catheter still in place. I was taken to the Chester County Prison infirmary where I was shackled to the bed even though it was a secured room and I had a guard at my bedside twenty-four hours a day.

I deteriorated over the next five days, with increasing abdominal pain and an inability to take anything by mouth. On December 25th, I had uncontrollable vomiting and had to be returned to the hospital on an emergency basis. A diagnosis of intestinal obstruction was made.

On December 28th, I had a five-hour abdominal operation to release adhesions and drain a large abdominal abscess that was discovered. I had a stormy post-operative course that included recurrent fevers, hepatitis, urinary obstruction, and an inability to eat that required weeks of total parenteral nutrition through a catheter in the neck. After five additional weeks of

hospitalization, I was discharged back to the prison, although I was in a very weakened state. One week later I had to be readmitted to the hospital for a third time because of recurrent fever.

At the beginning of February, 1986, I was transferred back to Holmesburg Prison in Philadelphia where I was placed in administrative segregation. I was in segregation during the next ten weeks while I received radiation therapy five days a week at the University of Pennsylvania.

I lost approximately 40 pounds in the period from December 1985 to April 1986, but I did go into a clinical remission. The cancer specialist recommended regular follow-up tests for at least five years.

Remission

I was convicted in 1987. At the time of sentencing the trial judge, the Hon. Louis H. Pollak, Eastern District of Pennsylvania, stated: "[I] recommend emphatically to the Bureau of Prisons that Dr. Berkman be assigned to a correctional facility capable of dealing with his medical circumstances."

The BOP responded by designating me to U.S.P. Marion. I was a first offender, with a twelve-year sentence, and no history of prison escape or violence. The 23-hour lockdown in a small windowless cell with a maximum of two hours of fresh air and sunshine a week were conditions likely to damage my immune system and allow the cancer to recur. Judge Pollak could not block my transfer to Marion, but he did convince the BOP to send

me to Springfield so doctors there could determine if I were healthy enough to go to Marion.

I was kept in the "hole" at Springfield. I was allowed out of my cell five hours per week: two hours in a cage outside, and three hours in a cage inside. My doctor was the Chief of Medicine, Dr. Nelson. I found him to be one of the most hostile, least competent, and least compassionate doctors I have ever met. Our encounters were limited, but I had the opportunity to listen to him speak with other prisoners as well. Jonathan, a 23-year-old prisoner on one side of me, suffered from an overactive thyroid. That condition can be treated with drugs, radioactive iodine, or surgery. Previously untreated young people with hyperthyroidism are almost always tried on medication. Dr. Nelson never told the young man of the three options; instead he told him that he had to take the radioactive iodine. He did not inform him of the side effects.

Terry's cell was on the other side of me. He was sent there from Marion because of recurrent bouts of hepatitis. I heard Dr. Nelson inform him that the liver abnormalities were caused by winter weather and depression. It was ludicrous. The prisoner was returned to the Marion Control Unit.

Pablo was the cell opposite me for part of the time. He was there to have a bullet removed from his buttocks. A nurse came to have him sign an informed consent/release form. He could not speak or read English, and the nurse knew no Spanish. Pablo asked if I could translate for him. The

release was for the removal of a lymph node, not a bullet. No one had told him that the doctor suspected he had lymph cancer.

Clay was next to Pablo. Clay had his gall bladder removed three weeks before I arrived. He was still at Springfield because his surgical wound was infected and was still draining pus.

At the far end of the hall, a prisoner spent a fair part of his time verbally harassing the staff; to me, he sounded confused and disoriented. He was never physically violent. The officers somehow got permission to put him in four cover restraints. This meant he was strapped spreadeagle to the bed and left there to urinate and defecate on himself. I believe the regulations state that such restraints can only be used for 24 hours. He wore restraints from Friday until Monday--72 hours of total immobility, covered with his own waste.

Carlos was in the cell opposite mine for a period of time. He was a Connecticut state prisoner who had been held in Marion for years. He had gone on a hunger strike to protest his long years in lockdown. Pursuant to BOP policy, he had been transferred to Springfield for forced feeding. Forced feeding has been condemned by every human rights group; the World Health Organization has called on physicians to refuse to participate in it. Yet it continues as BOP policy.

Forced feeding at Springfield is particularly brutal. After a cursory psychological examination to establish that a hunger striker is, by definition, suicidal, the prisoner is restrained. A large rubber feeding is then forced

down his gullet. After a liquid meal is administered, the feeding tube is removed rather than left in place. It is reinserted for every feeding, subjecting the patient to incredible pain.

Are these just "exceptions," as BOP Director Michael Quinlan described the cases featured in the "60 Minutes" segment? Or are these examples from one small unit, 2-1 East at Springfield, indicative of a pattern? I am sure that there are prisoners who have received good care and been helped at Springfield, but I witnessed neglect, abuse, and poor quality care. This took place in an environment that included almost constant lockdowns, recreation in a small dog kennel cage, and being taken handcuffed down the hall three times a week to be locked into a shower. Every thirty days, a psychologist came by and yelled through the locked door, "Are you o.k.?"

While it may be popular to demonize prisoners, we are human beings. Like other human beings, prisoners suffer pain, are frightened when they are sick, are desperate for human comfort and contact when confronting death.

And there are too many prisoners dying in prison. One of the most shocking experiences in my life was being taken through one of the wards at Springfield filled with elderly, dying prisoners. I hope and urge some of you to visit these wards and see what it means to die alone in prison. I know that when I was close to death last year, it gave me great comfort to have a loved one's hand to grasp.

That brings me to one last example from 2-1 East, Pedro. He was in his late 30's and was dying from inoperable, metastatic lung cancer. As he grew weaker, he could no longer take his occasional hour for recreation. His hacking cough and increasingly-labored respirations echoed down the tier every night. As we went to recreation or to a shower, we'd bang against his door and yell "hi" to him. That was his only human contact that I know of. All other times, he lay in his bunk staring at the ceiling, a black wall, or a barred window. I left before he died, so it is possible that he was transferred before he actually expired.

While FMC Rochester is quite different than Springfield, and I'll comment more on that later, one thing that they share is that too many prisoners are forced to die in prison who should be released. My first roommate at Rochester was a 27-year-old man with a massive tumor resistant to chemotherapy. The staff did not arrange for his release in timely fashion, and while he tried desperately to remain alive until his mother could come to his bedside, he was brain dead before she arrived. She stayed by his bed for a few hours, holding his hand, but had to leave because of the 4:00 p.m. "count." He died about an hour later. His experience is being repeated by numerous AIDS patients slowing dying in prison cells.

U.S.P. Marion

Before my arrival at Marion, my wife, who is also a physician, spoke with Dr. Del Valle, the doctor there. He was quite candid with her and told

her that he had never followed a patient with Hodgkin's Disease. My lawyer subsequently researched Dr. Del Valle's credentials and discovered that he had never been able to obtain a license and was not listed as a practicing physician with the American Medical Association.

I found Dr. Del Valle to be courteous and pleasant. However, I also found it disconcerting that he had to ask me what tests and X-rays were indicated as part of my follow-up care. After the X-rays were done, he asked me to read them. If this had solely been a matter of courtesy, I would certainly have appreciated it; however, I had the distinct impression that Dr. Del Valle, himself was uncomfortable with reading the films.

A medical license does not guarantee competence, and correspondingly, the lack of one does not guarantee incompetence. However, licensure and required continuing medical education are seemingly the best ways society has developed to insure a minimal level of knowledge by medical practitioners. The federal government has refused to adopt these standards. I understand that there are several doctors in the system, including three at Springfield, who are not licensed. The only thing possibly unique about Dr. Del Valle, then, is that he is the only doctor at Marion and has no colleagues with whom to confer.

I believe licensure or certification is a problem for physician's assistants in the BOP as well. At least one of the PAs at Marion told me that his only formal training had been as a medic in the military. The relatively brief training received by medics, with the emphasis on military trauma, is in

no way comparable to the training at a recognized Physician's Assistant school.

It is important for the committee to understand that both access to medical care and the daily practice of medicine is controlled by paramedical personnel. Everywhere I have been, including FMC Rochester, I have found this to be a problem. I worked closely with PAs and nurse practitioners for years, and I believe they can and do play an important role in health care delivery. In prison, they are the front line: they run sick call and visit patients on their units. It is a tough job and a vital one. The most important decision a primary care practitioner makes is the fundamental one of who is seriously ill and who is not. This requires knowledge and experience. PAs can play this role, but more often than not in my experience in the BOP, they play it poorly.

I believe that in terms of day-to-day care, the poor quality and lack of supervision of paramedical personnel is one of the biggest problems that the BOP faces. It will be compounded as the prisoner population increases.

Independently of the BOP, I was evaluated by Dr. George Solomon, one of the leading specialists in psychoneuroimmunology—the specialty concerned with the connection between stress and the body's resistance. Taking into account the lockdown and other conditions at Marion and other segregation units, and my history of recently having had cancer, he was willing, for the first time in his career, to make a prediction on a specific patient. Even though Hodgkin's Disease is often cured by the course of

radiotherapy I received, Dr. Solomon predicted it would recur if I were subjected to those extreme conditions. He proved to be right.

Cancer recurrence

I was transferred from Marion on a writ of habeas corpus ad prosequendum in 1988; I spent much of 1988-1990 at the D.C. jail in Washington, D.C. Pursuant to the recommendation of the U.S. Marshals, I was held in segregation. For a full year, I was never allowed to go outside; subsequently, the federal judge ordered that I be allowed two hours a week outside. My follow-up exams for the cancer were sporadic despite my constant reminders.

In March 1990, I had a CAT scan; it was seven months overdue. In early April, I discovered a mass in my lower abdomen, and a review of the CAT scan showed multiple enlarged nodes compatible with a recurrence of the cancer. Before treatment could be started, a biopsy had to be done. When both the D.C. Department of Corrections and the U.S. Marshals refused to schedule the biopsy, my attorney contacted the Hon. Louis H. Pollak, in Philadelphia and the Assistant United States Attorney responsible for my case. The AUSA then contacted the chief counsel for the BOP.

I requested to go to FMC Rochester for the biopsy and subsequent chemotherapy; my second choice was to be treated in Washington. The BOP's position was that I could only be sent to Springfield. Judge Pollak, having heard testimony about Springfield at the 1985 hearing, told the BOP

that Springfield was not acceptable. On April 25th, Judge Pollak issued an order directing the BOP to send me to Rochester or to have the biopsy done in Washington. The BOP refused to obey the order and notified my attorney that I was to be returned to Marion where Dr. Del Valle would decide if he thought a biopsy was indicated; if so, I would then be sent back to 2-1 East in Springfield. Judge Pollak blocked that transfer.

I grew more desperate. From my clinical condition and the CAT scan, I knew the cancer was back. I knew time was running out. And I also knew that getting treated with intensive chemotherapy at Springfield was a death sentence.

The prison doctor at D.C. jail broke the deadlock and arranged for a biopsy at Howard University Hospital. It was done under the direction of the U.S. Marshals. I was kept shackled on the operating table while under general anesthesia with my abdominal wall flapped open. The biopsy was positive for Hodgkin's Disease.

The next day, May 4, 1990, there was a conference call among Judge Pollak, the BOP, and my lawyer. The BOP assured Judge Pollak that Springfield had a contract arrangement with a board-certified oncologist who would supervise my treatment. My lawyers then called the county medical society in Springfield and researched that doctor's credentials. Contrary to the BOP's statement, he had not passed the oncology boards (board certified), and he was not even eligible to take them because he lacked sufficient

training. He was not a member of either of the two major medical societies for cancer specialists.

We so notified Judge Pollak. During a subsequent conference call, he again told the BOP that Springfield was not acceptable and urged them to send me to Rochester. They refused. On May 13, the AUSA notified my attorney that they were moving to lift Judge Pollak's order barring my transfer to Springfield. On May 14th, a column by Anthony Lewis concerning my situation appeared in the New York Times. That afternoon I was offered an agreement under which I would be treated in the prison lockward at D.C. General. I agreed.

I would like to briefly explain why I was and am convinced that receiving intensive chemotherapy at Springfield would have resulted in my death.

I had deep and well-justified doubts about the competency of Dr. Nelson as my primary physician there, and I also questioned the competency of the contract oncologist who would be supervising the therapy. But an even deeper problem was that Springfield, as a hospital, was neither equipped nor staffed to adequately care for seriously-ill medical or surgical patients. For example, during chemotherapy, the patient loses his or her ability to fight off infection. Since I had a prior round of extensive radiation therapy, I was even more likely than most chemo patients to have such problems. Overwhelming infection—sepsis—is the most common cause of death of patients receiving intensive chemotherapy. Since a patient with a

compromised immune system who is infected can go into shock and die in a matter of hours, immediate and effective diagnosis and treatment is vital. Under optimal conditions, an episode of septic shock in an immune-compromised patient carries a mortality rate of approximately 55%.

The conditions at Springfield, to the best of my knowledge and experience, were far from optimal. When I was there, there were no doctors at the hospital after 4:00 p.m. on weekdays or at all on weekends; they took calls from their homes, which could be quite a distance away. The psychiatrists who worked on the psychiatric ward took calls for the medical and surgical patients, even though they had little or no training in medicine or post-operative care. The X-ray and lab facilities were closed after 4 p.m. and on weekends.

I had three episodes of septic shock during the eight months I was hospitalized. The first occurred on a Sunday; I remember it well because I heard the N.Y. Giant/Washington Redskins football game on the television as I faded in and out of consciousness. It took three doctors, including an attending surgeon, to stabilize me. I required 24-hour, one-on-one, intensive care nursing. I was on six different antibiotics, a drug to keep my blood pressure stable, and received multiple transfusions.

I firmly believe that if this episode had occurred at Springfield, I would not have survived.

The BOP will undoubtedly respond that critically ill patients are transferred to a community hospital. The reality is that even if the doctor on

call is prepared to make that decision, he cannot effect it. The doctor has to convince the Warden of the urgency of the transfer, and the Warden then has to pull together a number of guards sufficient to make the move and stay with the patient. By the time that would have happened, Alan Berkman would have been dead.

Why did the BOP refuse to send me to Rochester, as I requested on numerous occasions and as Judge Pollak ordered? Their answer was that I was a high security prisoner. I was condemned to die unnecessarily because a prison bureaucrat had incorrectly made me a level 5 instead of a level 4, or because some other official decided to send me to Marion in violation of the established regulations.

My case is not unique. If you are a maximum security male prisoner in the BOP, and you become ill, you go to Springfield. If Springfield is not equipped to handle your illness, as they were not equipped to handle mine, you go there anyway. A long sentence (or even a medium or short one) becomes a death sentence.

I do not know if this policy of triage is written down somewhere, but I know that it operates. It happened to me. I was with many prisoners from Marion, Leavenworth, and Lompoc while I was at Springfield, but I have not met any prisoners from those institutions while at Rochester.

Civilian doctors and hospitals triage patients, governed by the principle that sick patients who will benefit from sophisticated hospitals go to them. It saves lives. The BOP has established a triage system, governed by

the principle that "security" determines level of care and chance of survival. I earnestly hope that the Committee will direct the BOP to change this inhuman practice.

Lastly, this issue of "security" is indefensible even on its own terms. While the security of institutions and of the prisoners must necessarily be of concern to the BOP, I do believe it is largely a red herring when it comes to medical care. Over the years, I have experienced pretty much every way the BOP and U.S. Marshals can secure a prisoner. I know for myself, and I believe this is true for other seriously ill high-security prisoners, that I would rather be locked down or even shackled to a bed at FMC Rochester than be treated at Springfield. Prisoners, too want to live.

Rehabilitation - FMC Rochester

My course of chemotherapy was extremely stormy and lasted almost eight months. In addition to the general debilitation that accompanies cancer and its treatment, I suffered paralysis of my legs and arms and moderate damage to my heart. My doctors and consulting physicians all recommended that I be transferred to a hospital specializing in rehabilitation therapy.

This did not happen, but after further negotiations with the BOP, I was transferred to FMC Rochester.

Rochester is far superior to Springfield. The close connection to the Mayo Clinic means that top quality care and consultation are available. The Mayo affiliation also makes Rochester a more attractive environment for BOP

doctors to work, and with only an occasional exception, the medical staff at Rochester seems competent and professional. Here too, however, I believe that the physician assistants are not adequately trained and supervised.

I would like to give one example from my own experience to illustrate the difference between Springfield and Rochester.

About one month after my transfer to Rochester, I spiked a fever of 103 accompanied by chills. It was a Sunday evening, and my floor was covered by a PA. The officer on duty called the PA, who said he was busy but would try to stop by later. After an hour or two, another prisoner told me he had seen the PA using the bathroom on the floor. I went and stood outside that door and spoke with the PA when he came out. I briefly told him my medical history and my recent symptoms. The PA told me to take an aspirin and see a nurse in the morning. I asked him if he would at least check my temperature and examine me. He said no, because there was nothing he would treat me for on a Sunday night.

I went back to bed but began to feel worse. A prisoner somehow spoke to a nurse on the floor above me and she came down to see me. When she saw me and checked my temperature, she went back upstairs and got the doctor who was covering there to come down and see me. Rochester uses physicians in training from Mayo to cover the hospital from 6:00 p.m. to 6:00 a.m. and on weekends. This young doctor decided to transfer me upstairs to the more acute unit. Within a few hours, basic blood tests were drawn and came back, and the X-ray technician was called in and took the chest X-ray

the doctor ordered. With this information at hand, the doctor was able to start appropriate intravenous antibiotic coverage by 1:00 a.m.

If Rochester can arrange to have young, well-trained doctors moonlight at night and on weekends, why can't Springfield, which is larger and has post-operative patients? Why can't the lab and X-ray facilities respond the same way at Springfield? The positive aspects of care at Rochester should serve as a model that brings up the quality of care throughout the system. I am afraid, though, that it will remain an exception serving a public relations function by deflecting needed criticisms away from other aspects of health care in the BOP. I hope the committee addresses this problem.

Other Issues in Prison Medicine

A) In the "60 Minutes" broadcast, Director Quinlan responded to questions about the featured cases by labelling them "exceptions." He quite correctly pointed out that there are bad outcomes at community hospitals, as well.

As I have tried to prove, I do not my case or my concerns were "exceptional." The defects in care in Springfield; the poor quality of some of the physicians, the lack of medical coverage and lab facilities; are systemic problems. While I have no basis to make statistical analysis of the care at Springfield, my subjective impression from my stay there is that the morbidity and mortality would exceed that of a comparable community hospital.

In medicine, as in many other fields, it is through the study of exceptional cases that the most important lessons are learned. The vast majority of patients who go to a doctor—some studies estimate as high as 85%—get better on their own; the human body is a wonderful machine. That is why teaching hospitals have death or mortality conferences, and why medical journals often feature case studies of patients who were misdiagnosed and/or incorrectly treated. These are the cases that illuminate systemic flaws.

I think all three cases featured in the "60 Minutes" segment exemplify systemic problems: medication being taken from a new prisoner and not replaced, surgery being done by a doctor inadequately trained to do it, a prisoner being triaged to Springfield for a life-threatening illness that it was not equipped to treat. The only thing "exceptional" about these cases is that they got public attention.

No one likes criticism. The medical profession is notoriously self-protective and has historically claimed the right to be self-policing. The prison system is worse in this regard, and prison medicine combines the bad features of both.

Patients are prisoners, who are relatively powerless, often poor, and with limited civil rights. It is hard for a prisoner to make his or her voice heard in the face of those obstacles. If he or she does succeed, there is all too frequently the direct threat of retaliation. I recently witnessed an encounter between a stroke patient and his doctor over whether or not the doctor

would give permission for the prisoner to have a fan in his room. They disagreed, but no voices were raised, and it was a civil exchange. When the patient persisted, the doctor said the patient was refusing treatment and would be transferred from Rochester. The patient was aghast because there had been no discussion about treatment, and certainly no refusal on his part. Ultimately, the transfer did not take place, but the threat of stopping medical care or of transfer to a less expert facility was there.

The courts cannot be a substitute for effective oversight. A patient incorrectly operated on is harmed for life; a patient who becomes critically ill when no doctor is available will likely die. There is no recourse. The courts cannot direct the BOP to send a prisoner-patient to one facility or another; you may recall in my case, the BOP openly refused to obey a formal order from a federal judge. And finally, even in cases of gross negligence or malpractice, the patient who is a prisoner must meet a higher legal standard of proof than an free person, demonstrating deliberate indifference rather than simple negligence.

B) BOP officials have stated that BOP medicine meets community standards of care. This strikes me as painfully ironic when some BOP facilities are staffed by physicians and paramedical personnel who are not licensed and could not practice in any community.

C) Many of the problems of prison medicine are rationalized away by prison officials who contend that prisoners make particularly poor patients. In a recent Washington Post article, Director Quinlan was quoted as saying

that part of the difficulty that the BOP faces in recruiting physicians is the dangerous and manipulative nature of prisoners.

I dispute that characterization. I have worked as a prison doctor, and I have lived among the highest security and presumably most dangerous prisoners in this country. On a number of occasions, I have seen prisoners hurt each other; on a few occasions, I have seen prisoners hurt guards; I have never seen nor directly heard of a prisoner hurting a medical person. I know it must have happened, but I am sure it is a rare occurrence. Such statistics are probably available, and it would be informative to check them before accepting the statement that prisoners pose a threat to medical personnel.

The myth of violence toward medical personnel is very actively promoted by the security staff. When I first started working at a prison, both the security and medical people emphasized the need for protection and the importance of not being manipulated by prisoners. A doctor who shows respect for the prisoner-patient or perhaps even compassion, is quickly notified by the security staff in a thousand different ways that such behavior is inappropriate and perhaps dangerous. One of the more concerned doctors at Rochester is disparagingly referred to as "Mama" by some of the correctional staff because of her concern for her patient's welfare.

I have been a doctor for twenty years, and I assure you that it is impossible to make a correct diagnosis if you discount what your patient tells you as a lie. The patient's description of how he or she feels is the most

valuable part of a medical evaluation. And without compassion, how can a physician fulfill his or her role as healer and comforter to the ill and dying?

This does not mean that prisoner/patients never lie or manipulate. They can definitely have ulterior motives. Yet so can many patients in private practice or in the military. Every doctor knows what it feels like to be manipulated by a patient who wants pain killers or tranquilizers. In civilian practice, some patients try to convince the doctor to declare them eligible for workman's compensation or disability. Some doctors specialize in exaggerating patients injuries from an accident for insurance purposes. As long as illness can deliver secondary gain, in prison or outside of it, practitioners will have to know how to recognize and firmly deal with manipulation.

From my perspective as a prisoner, the true forces governing prison life are power and domination. The technique of mass control used are not so different than those of a military force occupying a conquered territory. Medicine, to be effective, must be based on co-operation and individual attention. There will always be a conflict, but if medical care is to reach the community standard, the practitioners cannot be inculcated with the attitude of the correction staff. Security concerns are the context in which prison medicine is practiced, but it is disastrous if they become the overwhelming content.

Summary and Recommendations

- 1) The mission of Springfield as a nominally full service hospital should be re-evaluated.
- 2) Medical triage inside the BOP should be based on the prisoner's illness and need for sophisticated care, not on his or her security status.
- 3) Physicians and PAs should be required to obtain licensure.
- 4) The Morbidity and Mortality Committee at various BOP facilities should have outside physicians or members. This would hopefully dispel some of the insularity and secretness of prison health care and give some reality to the commitment to achieve the community standard of care.
- 5) Individual federal prisons should be accredited by the National Committee for Correctional Health Care. This would be in addition to the Joint Commission accreditation of the hospital facilities.
- 6) I believe there should be a review of the number of patients dying in prison who are eligible for compassionate release under 4205(g). Too many patients terminal with AIDS, cancer, and other diseases are unnecessarily

spending their last days in prison. Congress made its intention clear by passing 4205(g); I do not believe it is being implemented.

7) The policy of forced feeding of hunger strikers should be ended.

8) I have not addressed the growing problem of HIV-related disease among prisoners. Having seen the incredible suffering such patients undergo, I would urge the Committee to review BOP policies and practices in regard to these prisoners. I have also not touched on the particular issues relevant to women's health care, but the growing population of women prisoners makes this a priority.

Again, I thank you for this opportunity.

ST. PAUL OFFICE: 2600 WORLD TRADE CENTER ST. PAUL, MN 55101

APPENDIX 6.—LETTER FROM RINALDO REINO, PRISON INMATE, TO CHAIRMAN WILLIAM J. HUGHES, AUGUST 12, 1991

August 12, 1991

Senator William J. Hughes
House of Representatives
Committee On The Judiciary
2138 Rayburn House Office Building
Washington, D.C. 20515-6216

Dear Senator Hughes,

I am sending you this letter in response to your letter of August 1st, thanking me for my testimony. When it came, I was in the hospital. There is where I made up my mind to put this all behind me and get on with my life.

Senator, your letter and gift changed all that, I will cherish them for the rest of life. If a man like me can get a letter, that says United States Congress, then maybe something can be done. I thank you for that.

In your letter you said, if anything arises from my testimony to let you know. I will let you decide whether or not it has. It began at 11:00 P.M. in Rockchester, Minnesota, Tuesday-July 16th. I was asked by a P.A. to get ready to go downstairs to receiving and discharge to get dressed and leave for Washington. We left about 4:00 A.M., Wednesday-July 17th and arrived after 7:00 A.M. and came directly to the hearing. On the flight I had a cup of coffee and a roll. I believe you adjourn for lunch around 11:30 A.M. After our testimony, the P.A. gave me a lunch box with a half of pint of milk, and told me they were taking me to the hospital. On the way I was told they were taking me to the D.C. Jail and put in the infirmary. Instead, I was put in a holding cell, where my lunch disappeared. Now it was 3:00 P.M.. I was told to get undressed and get ready to go up to the infirmary. I asked for help, they said "no". So with the help of an inmate I got undressed. There I sat naked until 5:00 P.M., it was only then when I received a pair of overalls. I was put into another cell, where I stayed till 2:30 A.M., Thursday-July 18. All this time in my wheelchair and no food.

When I arrived upstairs a doctor questioned me. A half-hour went by and I was asked about my medication. I told him it was given to the receiving office and that was the last I heard of that. At 5:00 A.M., (still in my chair and no food) I was told they were taking me to court. I said, I was frightened with court - would they call the Marshalls office to find out. I was told to shut-up, do what I was told and a few other words.

Senator, I want you to understand, I am not a nice person when someone harasses me. I was so close to getting home, I held my tongue, told myself another 24 hours and its over. Home was something I never thought would happen and I did not want anything to change that.

I wee taken to the Marshalle holding pen at 7:00 A.M., at 11:00 A.M. nne of the Marshalle gave me a beg with sandwiches. By thie time I wee so eick, I could ^{not} eat. It wee 12:00, one nf the Marshalle who brought me in pased my cell and asked what I wee doing there. I explained, than asked if he would bring me upstaire to Court, so they could see for themselves what wee going nn.

He seemed very upest, he said he hed called right after they left me there to take me back. The man left and returned io 10 or 15 minutes. Seid, he spnke tn the captain at the jell, as we were talking (maybe 15 minutes) they came tn take me back.

Agalo, it started all over again. I changed my clothees (with the help of a inmate), put in e holding pen agein until 9-10 o'clock that night, than upstaire to infirmary. Doctors examined me, asked about the medicatinn, tnld them the esms thing. They could oot believe i was there siyce Wednesday and was not given any of my medicatioo or a bed. Wheo ths doctor saw the conditioo of my lege he called a Lieutenant fnr my medicatinn and a bed.

Now, they put me in e bed, 11:30 Thursday night they wnke me up at 5:00 A.M. gave me pancekes and milk, tnuk me downstaire to wait for e Marshell. I arrived bome about 11:00 o'clock, Friday the 19th. A total of more then 60 hre. in e wheelcheir, lees thao 5 hre. oo e bed and very little food. Seoator, you judge what happened. Wee it Racial? I wee the only white man there nr wee it just plain Harrasmoot? I doo't know, you decids.

I hope you receive thie letter bfore you leave for Springfield. Here ere a few oamee I would like you to see.....

Jimmie Luma	00790-032	
Vito Maogo	33270-438	
Mr. Nicholas	3-2 Weet	<u>A Must</u>

Mr. Nicholas ie a man 650 lbs. beeo thera for three years. He claime he has wrtteo to evaryoos and oo anawer. This mao does not know what a bath is. He hee nnt had one io ths time he's beeo there. He has an infectioo oo ths bottom of hie stomach, whatever you waot to call it, it laye oo the floor on a sheet. Its like boncals on a ship. He smells awful, all hs wants ia to take a bath. No nne wants to bs near him. Please, "Seoator see him," I promised tn say something on hie behalf.

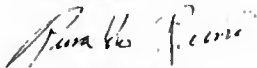
I cnuid go nn and on and tell you so much about men who died, whn used to beg me to etey at their bedeides and talk to them, knowing that tommrow they could die alnne, ee ec many did. If you ever eew a man cry, then maybe you cnuld underetend what I'm trving to tell you. I know because I weot through the same thing three different times. For some reasenn the men up there pulled me through. Why me, I don't know, maybe it was so that I could tell you what ie going nn. I would like tn believe that. I know that many men would die regardleess nf the dncntre, but I dn know that some could be eaved with the right cere and gond doctors.

Director Quinlin said, that the system was short about 50 personnel. Senator its not the quantity of doctors, the problem is quality. We both know most of the law suits are not true, but even if a third of them are true. The money the government pays out they could afford the best.

Director Quinlin said that 60 Minutes story was unfair. I don't think they went far enough.

Senator, I want you to know that if you need me again, in anyway, please don't hesitate to ask. I would do anything I have to. Thank you for making me a better citizen. Maybe, in time the faces that haunt me will go away. Only then I'll know that I did something for my fellow man. Regardless, of who they are.

Sincerely,



Rinaldo Raino

RR:pjr

APPENDIX 7.—A SERIES OF ARTICLES FROM THE DALLAS MORNING NEWS
CONCERNING MEDICAL CARE IN FEDERAL PRISONS

The Dallas Morning News

Year's Leading Newspaper

Dallas, Texas, Sunday, June 24, 1950

24 Sections 4¢ 11.00

Bad medicine imperils federal inmates

Staff shortages, crowding hurt quality of care



First of six parts

By Olive Talley

Staff Writer of The Dallas Morning News

© 1950 The Dallas Morning News

Rossie Holley was a healthy 33-year-old carpenter from South Texas when he was sentenced to federal prison for falsifying gun records. He was released early — disabled and impotent — because of what officials called the "devastating effects" of surgery he underwent at the U.S. Medical Center for Federal Prisoners.

Sam Firth, a 56-year-old former truck driver convicted of hauling cocaine, died of a heart attack at the same prison medical

center, in Springfield, Mo. He had suffered chest pains for several hours without examination by a doctor. A prison doctor later concluded that Mr. Firth's death likely could have been prevented.

Danny Rasmert, sentenced to seven years in federal prison on a tax conviction, was blinded by an overdose of drugs prescribed by a Kentucky prison doctor whose practice behind bars ultimately cost him his medical



Mike Newman, a physical therapy assistant at the U.S. Medical Center for Federal Prisoners in Springfield, Mo., helps 65-year-old Russell Wolfson, left partially

paralyzed by a stroke, walk during a therapy session. The Springfield center is the largest medical facility operated by the U.S. Bureau of Prisons.

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

Bungling, neglect afflict prison medicine

ILLINOIS.

Imbellea Searns, in a federal lockup in Chicago on charges of stealing mail, lapsed into a coma and died after prison officials withheld her medication for epilepsy, according to inmates who were incarcerated with her. Charges against the 41-year-old mother had been dropped shortly before her death.

Criminologists and penal experts long have regarded the U.S. Bureau of Prisons — and its health care for inmates — as the Cadillac of the nation's network of state and federal prisons. But an investigation by *The Dallas Morning News* reveals a medical system plagued by severe overcrowding, critical shortages of doctors, nurses and physician's assistants, and life-threatening delays in transfers of inmate patients to major prison hospitals.

Basic health care for prisoners scattered among 33 federal prison facilities — Texas has the most in the nation with seven — also is thwarted by security considerations, tight budgets, bureaucratic delays and legal entanglements, *The News* discovered.

“The health care we provide is good care, quality care. In some instances, it's even better care than an individual who is not an inmate would have access to.”

Dr. Kenneth Moritsugu

The result, according to interviews with prison personnel and inmates, as well as reviews of lawsuits and internal documents, is a health care system that, while providing good care for many, sometimes creates needless suffering and death.

Today, the nearly 30,000 federal prisoners find themselves in a “take-it-or-leave-it” system in which inmates’ requests for second opinions rarely are granted, even when the inmates offer to pay out of their own pockets. Inmates are not allowed to look at their entire medical files.

Dr. Kenneth Moritsugu, medical director of the Bureau of Prisons, says inmates receive a “quality of care consistent with community standards” — a guideline established to meet the Constitution’s safeguards against cruel and unusual punishment.

However, many of those close to the prison health system say it lacks the oversight to shield captive patients from incompetent doctors and neglect.

More than half of the doctors who practice in the nation’s federal prisons fall into two diverse categories: young doctors fresh out of residency programs — most of whom are paying back the government for under-

writing their medical training — or older doctors who have retired from “free world” practices or who previously worked in other government institutions, such as the military or the Veterans Administration.

Perhaps the single biggest hurdle in providing medical care for inmates is the worsening shortage of doctors: The Bureau of Prisons is operating with 39 vacancies in its authorized medical/surgical staff of 129 doctors. And, according to Dr. Moritsugu, the prisons could be understaffed by as much as 60 percent by September.

The doctor shortage — compounded by even more severe shortages among registered nurses and physician’s assistants — could reach “disastrous crisis” proportions in the next 18 months, Dr. Moritsugu said.

In early May, President Bush announced plans to spend \$1 billion to accommodate 24,000 additional federal inmates by the early 1990s. That 30 percent increase in the prison population would gild the system’s already strapped medical system.

“If there is a significant weakness in the system,” Dr. Moritsugu said, “it is the shortage of health care providers.”

Since he took the post as medical director in December 1987, Dr. Moritsugu said, he has struggled to hire more medical personnel and make other improvements, particularly in the area of ensuring quality.

His efforts have been hampered, he said, by the inertia inherent in a bureaucracy of 14,000 and by the negative image of prison medicine, which drives away top-flight people.

“Over the last 18 months, I have been laboring against a long history ... with regard to a negative image in correctional health care in general, not even to speak within the BOP,” said Dr. Moritsugu.

Yet he is skeptical of inmate gripes.

However, complaints about shoddy health care in federal prisons are voiced not only by inmates but also by private doctors and lawyers and even prison medical personnel. Responses by the Bureau of Prisons, critics contend, has come slowly, if at all.

“As a former federal defender and lawyer in this field for 25 years, I can say without equivocation that medical service in the federal prison system is pathetic and unresponsive,” said John J. Cleary, a San Diego lawyer.

“I’d be reluctant to take my dog to them.”

Behind the project

The *Dallas Morning News* confined its inquiry to medical and surgical care within the U.S. Bureau of Prisons; psychiatric treatment was not examined. The yearlong investigation included interviews with more than 150 people who have firsthand knowledge of medical care behind bars — doctors, nurses and physician’s assistants; inmates; lawyers; prison advocates; and bureau officials.

The *News* also examined nearly 900 lawsuits in the federal jurisdictions in which the bureau’s three largest prison hospitals are situated. Prison officials denied several requests under the federal Freedom of Information Act for internal audits, accreditation surveys and backgrounds on medical staff members. The bureau also invoked the Privacy Act in refusing to discuss specifics of dozens of individual cases.

However, many internal memos and other documents were obtained by *The News* through individual sources outside of official Bureau of Prisons channels.

“If I were a sick inmate, I would feel that my only real hope for treatment would be to get myself outside.”

—David Irvin, ex-U.S. magistrate

David Irvin, a lawyer and former U.S. magistrate in Lexington, Ky., won a \$625,000 judgment against the Bureau of Prisons on behalf of an inmate whose leg had to be amputated because of what state medical examiners termed incompetent care.

“If I were a sick inmate,” Mr. Irvin said, “I would feel that my only real hope for treatment would be to get myself outside, either by far enough or to be referred outside for medical care.”

In Chicago last fall, U.S. District Judge Pratice Marshall declined to send a sick defendant to federal

The Boston Phoenix, Boston, June 22, 1989

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

prison because of "very disheartening instances" among other ill defendants he had sent to prison and who had not received adequate health care.

It is those beliefs that Dr. Moritz says he's working to dispel.

"For the most part, when somebody in the general public hears a mention of prison medicine, it raises the specter of dark corridors, bare bulbs, alcoholic physicians who may have lost their licenses in a state nearby and are here at the end of the road," said Dr. Moritz, a commissioned officer in the U.S. Public Health Service.

"In fact," he said, "the standards that we have put into place within the federal Bureau of Prisons certainly belie that. I would welcome anybody walking through one of our institutions and waiting through a health care unit and seeing the caliber and quality of the physical plant as well as the health care providers."

"The health care that we provide to the inmates within our custody is good care, quality care," he said. "In some instances, it's even better care than what an individual who is not an inmate would be able to have access to."

Indeed, *The News*, in its year-long inquiry, documented many instances in which prisoners received sophisticated treatment, including heart bypass surgery, cancer chemotherapy, kidney dialysis and even kidney transplants. Some prisoners have written the Department of Justice in appreciation of the medical care they received.

But in other cases, inmates had trouble getting seen by a physician or obtaining the most simple diagnostic tests.

Critics say that problems in prison health care primarily go unchecked because of a weak internal system of peer review, the Bureau of Prisons' self-imposed secrecy, inmates' lack of credibility among prison doctors and the public's attitude that prisoners deserve whatever happens to them.

Prison officials denied several requests under the Freedom of Information Act for documents on internal audits, accreditation surveys and litigation pertaining to medical care. The Bureau of Prisons also invoked the Privacy Act in refusing to discuss specifics of diseases of individual cases presented by *The News*.

The *News* confined its inquiry to medical and surgical treatment; psychiatric treatment was not examined. The *News* interviewed more than 150 people, including current and former prison staffers, past and present inmates, lawyers and prisoners' advocates. Nearly 900 lawsuits were examined in the federal jurisdictions in which the Bureau of Prisons' four largest federal prison medical facilities are situated. Among the findings:

■ Full-time doctors are not available at all of the 33 prison facilities. In some of the smaller prison units, inmates have access only to physician's assistants — medical

Below (from right) John Briggs, Mark Lockard and Willard Williams wait to see a physician's assistant at the Springfield facility's clinic.



Raymond Weber (above), an inmate at the Springfield facility, is administered chemotherapy by nurse Ida Junge.

personnel trained to screen but not treat patients — who decide whether the prisoners need to be examined by doctors. As a result, many inmates do not get prompt, proper diagnoses.

Inmate Larry Alphin, for example, said he complained for five months of nausea and abdominal pain at the U.S. Penitentiary in Terre Haute, Ind., physician's assistants accused him of faking illness. Only when Mr. Alphin had urinated two units of blood in a matter of hours was he seen by a doctor. The doctor diagnosed Mr. Alphin's illness as cancer; he died two years later at age 38.

■ Even when illnesses are diagnosed, treatment often is delayed so long that the illness becomes life-threatening. Linda Clark, 39, sentenced to 25 years for a bank robbery in Corpus Christi, was flown from West Virginia to a prison hospital in Lexington, Ky., for an emergency hysterectomy. Even though doctors in West Virginia believed

her life was in danger, she had to wait three months for the operation.

Sidney Mayley, 32, serving 25 years for bank robbery, had a history of cancer and had previously had surgery in prison for hip cancer. But it was six months after he notified prison officials of a suspicious lump on his jaw before he underwent diagnostic tests in Rochester, Minn. An outside doctor found that only immediate surgery could save Mr. Mayley's life, and an operation was performed within 24 hours. Mr. Mayley recently underwent reconstructive surgery and is recuperating.

■ Despite a government airlift operated jointly by the Bureau of Prisons and the U.S. Marshals Service, ill inmates — including some emergency patients — are forced to undergo long, circuitous trips to reach prison medical centers.

Prisoners assigned to bus transfers — which they call "diesel therapy" — are shackled at their hands and feet and chained to their seats for hours-long rides under conditions that one former federal magistrate described as "the pits."

In one example documented by a prison doctor, federal officials last year transferred an anemic inmate by emergency airlift, yet sent a cri-

The Boston Post, July 20, 1988

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

Crowding, staff shortages plague prison medicine

ically ill inmate — one with bleeding around his brain — more than 300 miles by ground ambulance from Kansas to Missouri.

Last December, the government paid an undisclosed settlement to the family of Vinale Harris, 31, of North Carolina, who died of asphyxiation after a guard taped his mouth shut with duct tape during a bus transfer.

Another inmate, August Masoro, suffered sudden cardiac arrest and died within 24 hours of his arrival at Rochester. According to a lawsuit filed by his family, the lethal attack occurred after a 13-hour bus transfer from Springfield, Mo.

Some female inmates have complained of being denied sanitary napkins while in transit.

Medical records often do not accompany inmates — even emergency patients — when they are transferred for medical care, according to memos obtained by *The News*. In the case of one inmate sent to the medical center at Springfield, former staff internist Dr. Dante Landucci wrote that "the patient arrived with so little documentation that it was impossible to know where he came from, let alone what was wrong with him."

Some doctors who practice in federal prisons lack American medical training or board certification to perform the specialty work that they practice.

A Mexico-trained doctor at the Federal Correctional Institution in Lexington lost his license after the Kentucky medical licensing board determined that he had failed to provide proper medical care to inmate Jose Serra. Mr. Serra won a \$425,000 judgment against the government after other medical experts testified that his leg had to be amputated because of Dr. Paul Pichardo's delays and failures in treatment of Mr. Serra's vascular problems.

When confronted with evidence of malpractice or neglect by doctors or other medical personnel, prison officials have responded slowly, if at all. In the Serra case, according to a former prison doctor, officials allowed Dr. Pichardo to resign rather than fire him, even after they determined that his treatment had been inadequate and that judgments against him totaled nearly \$1 million.

In Springfield, some members of the operating room staff were so concerned about the qualifications of one surgeon that they filed formal protests with the hospital administration. The complaints came after what staff members termed a wrongful death. Although the administration rescinded some of the surgeon's operating privileges, it allowed him to continue other kinds of operations.

For 13 years, the bureau has fought a lawsuit alleging the wrongful death of a Terre Haute inmate who died within 10 minutes of being administered what his family's attorney alleged was an inappropriate drug to counter an asthma attack. The inmate's family

says the prison doctor ordered the drug over the telephone without examining the patient. The doctor resigned from the prison system within the last five months amid pressure from a warden dissatisfied with his performance, said a source within the prison system.

The burden of providing medical care is exacerbated by overcrowding, understaffing and rising health care costs. According to the bureau's calculations, its facilities are overpopulated by an average of 60 percent, with some units, such as the Metropolitan Correctional Center in Miami, overcrowded by as much as 154 percent. Overcrowding is particularly acute at minimum-security camps, such as the newly opened Bryan, Texas, camp, which is overcrowded by 224 percent.

As the number of people convicted of federal crimes grows — particularly in drug cases — and ju-

Even though this inmate of the Springfield prison is more than 80 years old and walks with a cane, he is considered a security risk when he goes outside. He must wear shackles and be escorted by three correction officers.



“The patient arrived with so little documentation that it was impossible to know where he came from, let alone what was wrong with him.” — doctor, formerly on staff at Springfield prison hospital

only few of the hundreds of lawsuits filed by prisoners each year pertain to medical care, reflecting prisoners' satisfaction with the overall medical care they receive.

However, officials refused *The News'* request under the Freedom of Information Act for nationwide statistics on lawsuits filed against the agency. The

agency said its records on lawsuits are computerized in files containing other information that officials said is exempt from public disclosure.

Inmates and defense attorneys argue that most medical complaints never make it to the courtroom. Many inmates don't have money to hire lawyers. Other inmates fear reprisal. And many prisoners — and even lawyers — say they are deterred by the peculiarities and complexities of federal prisoner lawsuits that require inmates to exhaust lengthy administrative appeals before going to court.

Another barrier to lawsuits, critics say, is that prison doctors have

rise become more aggressive in contacting prison officials project that the inmate population could top 100,000 by the turn of the century.

The number of inmates grew by 73 percent in the five-year period ending in 1988, while staff levels increased by only 23 percent, according to the bureau's 1988 fiscal year budget. Between 1980 and 1988, the cost of outside medical care for inmates rose 305 percent to \$20.7 million.

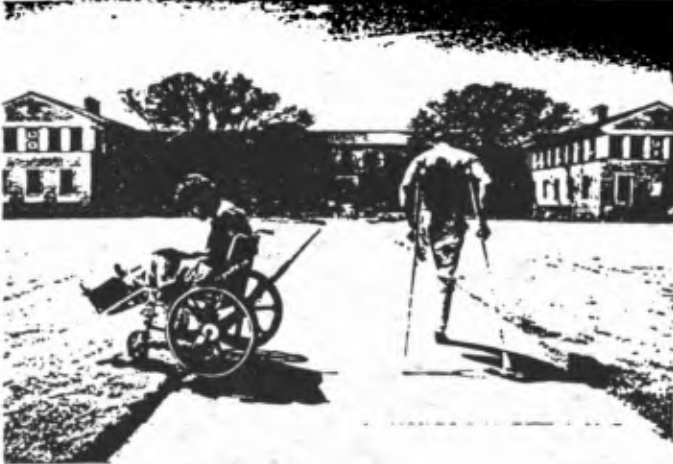
In addition to 39 vacancies among medical and surgical doctors, the bureau cannot fill 42 of the 296 authorized nurse jobs and 179 of the 408 authorized positions for physician's assistants.

At the Federal Correctional Institution in Milan, Mich., for example, the authorized medical complement is 17. Currently, one doctor and two physician's assistants provide medical care for more than 800 inmates.

Prison officials say that role-

City Bureau Reporting Agency Serial Date 1968

CARE AND PUNISHMENT: MEDICINE BEHIND BARS



The Dallas Morning News William Hester

Melvin Harrison, a prisoner at the Federal Corrections Institution in Fort Worth, enjoys a sunny spring day in the

facility's courtyard as a fellow inmate heads back to his cell after their lunch break.

governmental immunity from personal malpractice claims as long as they are working within the scope of their duties. Unlike proving negligence against a doctor in private practice, inmates also must prove that the prison system showed "deliberate indifference" to their medical needs. A prisoner, for example, could prove that a doctor was negligent but still not recover damages.

Even when inmates do succeed in exhausting administrative appeals and getting their cases heard in court, they almost always lose.

Of the nearly 900 lawsuits *The News* examined in Dallas, Fort Worth, Chicago, Lexington, Springfield and Minneapolis, less than two dozen resulted in favorable rulings for inmates.

Legalities aside, observers of the prison system say medical care behind bars inevitably is tinged by the abiding hostility between inmates and their keepers.

"It's not just the bureaucracy, but the attitude which prevents them (inmates) from obtaining treatment," said New York attorney Nathan Dershowitz. He represented Anne Raderford-Pollard, the wife and accomplice of convicted Israeli spy Jonathan Pollard, in an unsuccessful lawsuit alleging that she has received inadequate medical care.

Lawsuits filed by prisoners often

reveal the depth and sometimes absurd consequences of that struggle for power.

For example, prison officials in Springfield refused to allow inmate Clifford Radwine, a 43-year-old World War II veteran convicted on civil rights charges, to spend his own money on orthopedic shoes.

Mr. Radwine, according to his lawsuit, had owned one pair of orthopedic shoes for 10 years and had worn them in state and federal prison for the previous three years before they wore out. Mr. Radwine argued that prison-issue shoes hurt his feet, aggravating medical problems that caused him to miss work.

"Common sense may be at a premium here, but it would seem that permitting petitioners to buy the . . . medical shoes at his own expense would be the logical solution to this dilemma," Susan Spence, an assistant federal public defender in Springfield, wrote on Mr. Radwine's behalf.

After 16 months of legal wrangling, a judge granted Mr. Radwine's request.

Chicago attorney Jeffrey Steinbeck, who has represented dozens of inmates in federal prison, said the tug of war between inmates and jailers sometimes becomes so intense that authorities withhold medical treatment as punishment.

"You're a malingering, or I don't like you — so suffer," he said, de-

scribing the jundiced attitude of some prison doctors.

Doctors and nurses say, however, that it is difficult to sort out real symptoms from staged ailments, especially among a group of people who are largely manipulative, uneducated about their own physical well-being and who distrust any medical diagnosis they receive.

Medical staffers — even the guards — walk a tightrope in a monolithic system that makes no allowances for individuals, said Ivan Fells, who before his recent retirement spent 25 years as a guard.

"We've got some damn good people in this system. . . . They don't want to be coaxed by inmates, but they're terrified of government retaliation," Mr. Fells said.

In 1981, for example, Mr. Fells was criticized by superiors for providing a wheelchair — against a doctor's orders — to a convict who was dying of cancer and too weak to walk to the X-ray lab. "It was the humane thing to do," said Mr. Fells.

"The problem is having to apply the same standards to everyone when they're not alike — that's contrary to human values, because not everybody is alike. The good is not rewarded. . . .

"When you're in that environment so long," Mr. Fells said, "you look up and see another khaki uniform. It becomes a blur."

Prisoner died after bloody ordeal in surgery

Dr. Swanson declined to discuss the surgery he performed on Mr. Manson or his tenure as a staff surgeon at the U.S. Medical Center for Federal Prisoners at Springfield.

"My basic position," Dr. Swanson wrote *The Dallas Morning News*, "is that the press is not a proper forum for critique or judgement (sic) of the medical profession."

Dr. Swanson, a so-called "pay-back" physician, joined the prison system as part of his three-year obligation to the U.S. Public Health Service in return for government financing of his medical training. He had been working for about five months as a general surgeon at Springfield when he attempted to remove the cancerous tissue from Mr. Manson's right lung.

The surgeon graduated from the College of Osteopathic Medicine and Surgery in Des Moines, Iowa, in June 1981 and performed a three-year general surgery residency at the Michigan Osteopathic Medical Center in Detroit from 1982 to 1985, according to a spokeswoman at the American College of Osteopathic Surgery Officials at Lansing, Mich., said he completed the first year of a three-year training program in thoracic and cardiovascular surgery.

Dr. Swanson said in a brief interview that he left the training program "under duress" to fulfill his government obligation.

Even before the Manson surgery, according to several former and current operating room staffers, some members of the surgical team questioned whether Dr. Swanson had the training and technique to successfully perform the procedures he attempted.

"We had trouble with Swanson because he had poor communication with the OR (operating room) team and he was doing cases I didn't think he was qualified to do," said one former operating room nurse who asked not to be named for fear of retribution from prison authorities.

"He had a tendency to get in over his head," said another operating room staffer who also asked to remain unidentified. "I think Dr. Swanson had difficulties in recognizing his own limitations."

At least one operating room nurse said he asked Dr. Swanson's supervisor, Dr. James Clawson, the chief of health programs at the Springfield prison hospital, for a briefing on Dr. Swanson's training and surgical privileges. The nurse said Dr. Clawson refused to provide such information.

Among those who had questions was Mrs. Small, who frequently worked with Dr. Swanson.

"He's a very smart man," the nurse said. "The only thing that he's lacking... is common sense to say, 'I don't know what I'm doing. I need help. He has an ego problem.'"

Dr. William Hardman, a Springfield vascular surgeon who works as a consultant at the prison hospital, said Dr. Swanson's credentials look good on paper.

But in the operating room, Dr. Hardman said, Dr. Swanson is "dangerous."

Dr. Hardman said his experience with Dr. Swanson prompted him to write a letter to the board of Springfield Community Hospital, which later blocked Dr. Swanson's application for surgical privileges there.

"I said that although I thought his technical ability was probably adequate, his judgment is clearly not up to the standard of care that we practice here."

Verna Homer Manson last spoke to her husband on Feb. 5, 1987, one day before he was to undergo surgery at the nation's oldest and largest medical facility for federal inmates.

She could tell he was scared, and she tried her best to comfort him over the phone.

Circumstances, however, didn't lend themselves to comfort. He placed the call from behind the bars of a penitentiary hospital; she answered the call at the Federal Correctional Institution in Pleasanton, Calif., where she, too, was serving a prison sentence.

"I talked to the doctor (Dr. Swanson) who said it was a simple thing," Mrs. Manson said. "He said, 'It's going to be OK.'"

She was further reassured, she said, by the picture her husband had sent just a month earlier, one she had taped to the wall of her prison cell. It showed Lawrence Manson suited up for the prison softball team at the U.S. Penitentiary at Leavenworth, Kan., where before his illness he had been serving a 40-year sentence for bank robbery.

Despite being overweight, the 6-foot, mustachioed, dark-haired and dark-complexioned Mr. Manson had always appeared healthy, except for a nagging cough they both attributed to his incessant smoking of cigarettes.

They were married in Reno, Nev., in August 1985. He was on parole on a theft conviction; she was on the run from a federal halfway house in San Jose, Calif., where she had been completing a sentence for bank robbery.

"He had been waiting for years to get married," she said.

And there had been little companionship and love in Lawrence Manson's life. His parents, who had been in their 50s when he was born, were dead. His four siblings, who according to a prison psychiatric report were much older, wanted little to do with him, Mrs. Manson said.

Even before he married, Mr. Manson had spent most of his adult years behind bars. A two-year stint as a computer programmer was his longest period of gainful employment. It was preceded and followed by terms in county jails. California prisons and federal lockups for everything from forgery to selling drugs to robbing banks.

He also admitted to using drugs, and the FBI theorized that he pulled the bank robbery that landed him in Leavenworth to feed a \$250-a-day heroin habit.

But Mrs. Manson said that although her husband did need money to support a drug habit, it wasn't his — it was hers.

"He didn't want me out doing whatever I was going to do to support my drug use, so he did it for me," Mrs. Manson said. "It was his way of protecting me."

The month before the wedding, Mr. Manson began robbing banks up and down the California coast. FBI reports say he admitted to nine robberies between July 26 and Sept. 14, 1985. There were no injuries; the total take was \$14,564.

"He did not attempt to disguise himself," an FBI affidavit noted. "He would approach a bank teller and demand money indicating that he had a gun. He never displayed any weapons."

Mrs. Manson said she begged her husband to walk away from her and her expensive drug habits, but he refused.

"He didn't want to leave me, but he should have," she said.

Mrs. Manson said her husband told authorities that he occasionally used drugs, leading them to believe he had a drug habit.

"The court couldn't understand why he had gone into this," she said. "Larry wouldn't tell them, and they wouldn't let me testify at Larry's trial."

Mr. Manson was sentenced to 40 years — the maximum sentence for armed bank robbery — and sent to Leavenworth.

A year later, after he was transferred to the prison hospital at Springfield and cancer was diagnosed in his right lung, Mr. Manson sought reassurance from a prison nurse.

"He said, 'Jim Kemmer, do you think I need this surgery?'" recalled Mrs. Small, whose maiden name was Kemmer.

"I said, 'Manson, it is not within my realm to say whether you do or do not need it. You need to do whatever your heart tells you.'"

Mr. Manson followed his heart. He consented to surgery, but not before he drew up a will to provide what he could for the one person he loved — Verna Homer Manson.

Kelly Small assumed nursing care for Larry Manson about 8 a.m. on Saturday, Feb. 7, 1987, the day after his marathon surgery.

As she scanned the nursing notes from the previous shift, Mrs. Small saw that the patient had had a rough, restless night.

Nearly every 15 minutes, according to the chart, nurses had injected doses of Valium, a tranquilizer, and morphine sulfate, a painkiller, into intravenous lines attached to Mr. Manson's arms.

By 9 p.m., according to nurses on the log, his condition had been listed as critical.

Stops on monitors measured the rate of his heartbeats, and nurses kept constant tabs on his pulse and blood pressure.

An endotracheal tube running into his windpipe was attached to a

The Dallas Morning News

Times Leading Newspaper sold to you every day

Dallas, Texas, Sunday, June 25, 1967

25 Cents 10¢ a copy

A bloody ordeal in surgery led to prisoner's death

By Olive Talley

Staff Writer of The Dallas Morning News
© 1967 The Dallas Morning News

SPRINGFIELD, Mo. — The surgery scheduled for Feb. 6, 1967, posted on a shiny, white crissable board above the surgical suite, read: 9 a.m. — Lobectomy — Manson, Lawrence, Reg. No. 79006-011.

The operation at the U.S. Medical Center for Federal Prisoners, designed to remove a cancerous spot from prisoner Lawrence Manson's right lung, had been under way about an hour when crisis struck. "I can't ventilate this guy!" yelled Dr. George Corvix.

The surgical staff watched as the anesthesiologist strained vainly to squeeze air from the black, balloon-shaped air bag into Mr. Manson's windpipe.

The air bag had been pliable only an instant before, but now it was rigid like a football in Dr. Corvix's hands. It was the first sign that the 40-year-old Mr. Manson was in trouble.

Dr. Michael Swanson, the 41-year-old surgeon standing over the patient, cursed, freezing the scrub team in place.

The green-suited team watched anxiously as Dr. Swanson cut a hole in Mr. Manson's chest cavity, pierced the left bronchus and installed an air tube outside the body to re-establish the airflow be-



Dr. Michael Swanson

SURGERY GOES AWRY

On Feb. 6, 1967, Dr. Michael Swanson operated to remove a cancerous spot from inmate Lawrence Manson's right lung. The surgery went awry when Dr. Swanson, after stapling shut Mr. Manson's right bronchus, put a second staple and cut in his trachea, shutting off air to the left lung as well. The surgical team was forced to construct an emergency airway to Mr. Manson's left lung and attempt to repair his trachea. What should have been a four-hour procedure became a nine-hour ordeal in which Mr. Manson's blood was replaced three times.



tween the trachea and the left lung.

As oxygen whooshed steadily through the plastic tube into Mr. Manson's body, Dr. Swanson refocused his attention on the obstruction to Mr. Manson's breathing.

The surgeon, trying to close the airway to the right lung, mistakenly had stapled and cut Mr. Manson's trachea, cutting off air to both lungs.

It was the beginning, according to members of the scrub team, of a bloody ordeal. The surgery, scheduled for four hours, lasted nine. Dr. Swanson, assisted by Dr. Leland E. Wessel, Jr., removed Mr. Manson's entire right lung and reassembled his trachea.

As the doctors worked, operating room personnel recall, Mr. Manson literally spewed blood.

"By the gallons," said one nurse.

"We pumped blood as fast as could be done," said another. "We maybe replaced his blood three times. We gave him 16-17 units of blood" and more than 30 units of blood products.

"I'm surprised the man came off the table," said a third nurse.

By 6 p.m., when Mr. Manson finally was rolled into the recovery room, the scrub team was exhausted. And at least some of its members were furious.

The chief operating room nurse, Jon Jones, submitted his request for a transfer that afternoon.

But for registered nurse Kelly Small, the horror was only beginning.

Seventeen hours after the operation — after another of Dr. Swanson's procedures went awry — Mr. Manson gagged on his blood and died. It fell to Mrs. Small to help place the body into a black, tapered bag for shipment to a morgue.

Even now, Mrs. Small said, "I still have nightmares about that poor Mr. Manson."

CARE AND PUNISHMENT MEDICINE BEHIND BARS

machine that kept him breathing steadily. Holding the tube in place inside his trachea was an inflatable cuff at the base of the tube.

An anesthesiologist and nurse/anesthetist left strict orders, two nurses said, to keep the ventilator and endotracheal tube in place. Under no circumstances, the nurses said they were told, should the tube be removed.

"When I came on, he was stable," Mrs. Small said.

But there was trouble. "I kept hearing squeaking over his throat area, which told me there was either a leak in the cuff or something was wrong. I could not keep air in the cuff."

By 9:30 a.m., Mrs. Small notified Dr. Swanson of the leak.

"That was the start of the nightmare," the nurse said.

The doctor, who had spent the night in the prison hospital, was at the patient's side within 10 minutes.

Mrs. Small's nursing notes from 9:30 a.m. read: Dr. Swanson here, now attempting to re-intubate pt. (patient), due to the ET tube cuff having a leak. The pt was removed from the ventilator. Continuous CPR (cardiopulmonary resuscitation) Ambu bag done per KKK (Kleinman). Pt. very anxious and agitated.

The registered nurse remembers that morning vividly. "Obviously, he (Dr. Swanson) thought, 'What the hell, we'll put a new tube down.' So we disconnected him from the ventilator and I was pushing an Ambu bag (a breathing bag used in emergencies) to ventilate him. Swanson then tilted his neck back and was attempting to put another ET tube down while this other ET tube was already in."

"All of a sudden, I started getting blood back from that tube."

"When this started happening, I said, 'Can I call someone? Can I call Clawson (Dr. Swanson's supervisor)? Can I call (nurse/anesthetist) Dean Oates?'"

"No, no, no, we're fine," she quoted Dr. Swanson as saying.

"I was trying to suction this blood out that was coming back up and give him air all at the same time, which is almost impossible," Mrs. Small said.

"His heart rate started going down because he didn't have enough oxygen going to his brain or the rest of his body."

By 10 a.m., other nurses and a nurse supervisor had rushed to the room.

10:15 a.m.: After numerous attempts to re-intubate pt., Dr. Swanson attempted to put a tracheostomy tube in.

But he had no more luck inserting a tube through an incision in Mr. Manson's throat than he had in forcing one through the patient's mouth.

10:40 a.m.: The patient is now apneic (without a heartbeat). Dr. Swanson notified of this per S. Clair, RN Supervisor. Ms. Clair asked if further medical help was needed for airway insertion. This was denied per Dr. Swanson.

"He said, 'No, no, no, we're in deep shit now,'" Mrs. Small said.

When Mr. Manson's heart stopped, a Code Blue was sounded to signify a medical emergency. "We

started CPR and pumping on his chest, the whole nine yards," Mrs. Small said.

Five minutes later, Mr. Manson was given an intravenous injection of epinephrine to stimulate the adrenal glands and narrow the blood vessels.

10:49 a.m.: Monitor continues to read apneic.

More drugs, more CPR.

By 10:53 a.m., Mr. Manson's hands, feet and face had turned blue, and his skin was damp.

"Jesus Christ, the guy is brain-dead by now," Mrs. Small said.

At 11:03 a.m., Mr. Manson was shocked with electric paddles to jolt his heart.

No rhythm noted. Pt. remains apneic. No BP (blood pressure) or pulse noted.

11:06 a.m.: Code stopped. Pt. pronounced dead per Dr. Swanson.

About 15 minutes later, Dr. Swanson was crunched over a phone, breaking the news of the death to Mrs. Manson in her prison in California.

"He said he was in recovery and doing quite well, but that blood started draining hard into the left lung," Mrs. Manson recalled.

Her husband had died, Dr. Swanson told her, of "complications from the operation."

She said the doctor previously had said tests indicated that the cancer was confined to the top section of the right lung, but "when they opened him up, it was a different story and they had to take the whole lung and that the cancer had gone into the lymph glands and that he would have been dead in a short time if he hadn't died after the surgery."

The autopsy report, however, showed that the cancer was confined to the upper lobe (branch) of the right lung and "no metastases" were found in the lymph nodes.

12:49 a.m.: Pt. wrapped in shroud pack and escorted to R&D (receiving and discharge, where all inmates enter and exit the prison) per gurney, per Lt. Hensley.

The recovery room was a bloody mess.

"When we turned him over, out of that little incision (where Dr. Swanson had tried the tracheostomy), which was probably not even an inch long in his neck, at least five or six quarts of blood just poured out all over the floor," Mrs. Small said.

The autopsy report said: "This 40-year-old white male died possibly as a result of mechanical obstruction secondary to postoperative hemorrhage from the transbronchial anastomosis site."

In lay terms, according to Dr. Linda Norton, a Dallas forensic pathologist retained by The News, Mr. Manson died of a combination of problems: the unsuccessful attempt to insert a second air tube into his throat blocked the air to his lung, and bleeding from a surgical site spurted into his lung and throat.

"When I got the death certificate," Mrs. Manson said, "it said he died of natural causes, not from cancer or from, you know, complications. It was like he died an old man."

Word of the Manson surgery spread. "We've never had a situation where everyone was so upset," said one registered nurse at seven years' tenure at the hospital.

Seven months later — in the face of mounting staff complaints — a retired Mayo Clinic doctor then employed by the Federal Medical Center in Rochester, Minn., was brought in to review Dr. Swanson's case.

Prison authorities would not release the report of Dr. Philip Burnett, but they said his recommendations resulted in Dr. Swanson being restricted from performing surgery similar to Mr. Manson's or other complicated thoracic procedures.

Mrs. Small ruminates last fall from the U.S. Medical Center for Federal Prisoners at Springfield, five days short of qualifying for career benefits.

"I couldn't work there anymore," she said. "I had been put into so many positions where I didn't feel comfortable . . . (where) the patient's life was on the line."

Having completed his Public Health Service obligation at Springfield, Dr. Swanson left the prison system last week.

In his letter refusing to be interviewed, Dr. Swanson wrote *The News*:

"You should be aware that my treatment of various federal inmates has been reviewed by qualified individuals, both within and outside the Bureau of Prisons. As far as I am concerned, there can be no redeeming value or constructive benefit to additional review or trial by the press."

"In closing, I quote a recent address by Clement A. Herbert, M.D., Maccabreations of the surgeon are chiseled on the granite of graveyards, and the remembrance of them lingers in the solar plexus. Our helm is true and the cleansing agency of open confession before our peers."

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

INSIDE THE WALLS: HOW THE PRISON MEDICAL SYSTEM WORKS



The delivery of medical care in the federal prisons often is a haphazard process. The medical system is a patchwork of federal, state, and local health facilities. The federal system is a mix of federal, state, and local health facilities. The federal system is a mix of federal, state, and local health facilities.

1 When an inmate generally must wait with the rest "back out" to the medical unit. The medical unit is a mix of federal, state, and local health facilities. The federal system is a mix of federal, state, and local health facilities.

2 A physician's office is a doctor. The doctor conducts the inmate's examination. If the inmate is a federal inmate, the doctor is a federal doctor. If the inmate is a state inmate, the doctor is a state doctor. If the inmate is a local inmate, the doctor is a local doctor.

3 Most of the 10 have doctors. The doctor conducts the inmate's examination. If the inmate is a federal inmate, the doctor is a federal doctor. If the inmate is a state inmate, the doctor is a state doctor. If the inmate is a local inmate, the doctor is a local doctor.

4 If a prisoner requests an examination, he generally is transferred to one of the Bureau of Prisons' medical centers. These centers are located in various parts of the country. The centers are located in various parts of the country.

5 The three top-level medical centers are located in Springfield, Mass., and Springfield, Mass. The centers are located in various parts of the country. The centers are located in various parts of the country.

6 Some inmates are transferred to the medical units. The medical units are located in various parts of the country. The medical units are located in various parts of the country.

7 Finally, a few inmates are transferred to the medical units. The medical units are located in various parts of the country. The medical units are located in various parts of the country.

The illustration is by Arthur G. ...

The Dallas Morning News

Times' Leading Newspaper

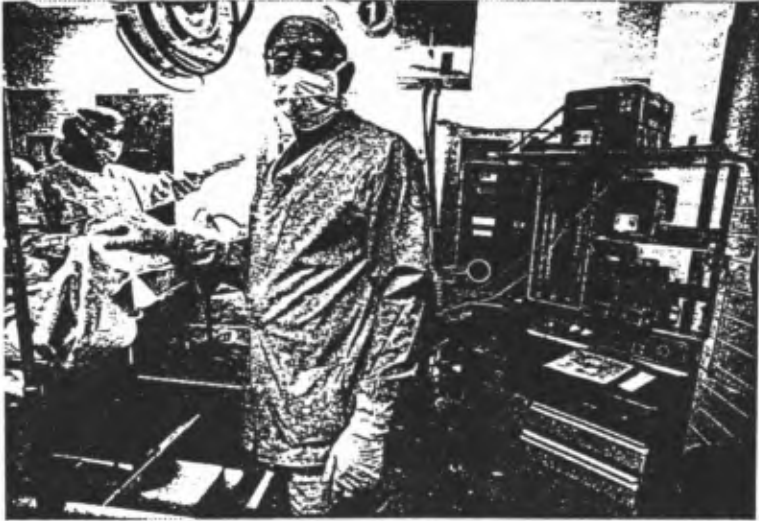
Dallas, Texas, Monday, June 26, 1989

6 Sections

p. 6

***** 25 Cents

Prison physicians' work scrutinized



The Dallas Morning News: William Snyder

Dr. George Corvin became chief anesthesiologist at the U.S. Medical Center for Federal Prisoners in Springfield, Mo., in 1967. The chief of health pro-

grams at the prison praises Dr. Corvin, although some private physicians in Springfield have expressed reservations about his previous work.

Some inmates harmed, not healed

Doctors sometimes try treatments beyond their expertise

"No one's condition should be made worse because of having visited a physician," — from the Hippocratic Oath.

Second of six parts
By Olive Talley

Staff Writer of The Dallas Morning News
© 1989 The Dallas Morning News

First do no harm. It is the simplest and most basic of a doctor's duties. Yet the nation's nearly 20,000 federal inmates give their lives daily to a corps of doctors, some of whom have caused grievous harm.

Worse than years of isolation from society, prisoners find themselves at the mercy of an inconsistent medical system that too frequently allows doctors to perform beyond their experience and training.

For these luckless inmates/prisoners, their punishment sometimes transcends the court's sentencing to include inadvertent and needless suffering, lifetime disfigure-



Prison doctors' concerns. SA

ment or, in some cases, death. Last year, for example, a doctor at the Federal Correctional Institution in Lexington, Ky., was suspended by licensing officials after his treatment of a prisoner was found to be grossly incompetent.

At the U.S. Bureau of Prisons' largest hospital, in Springfield, Mo., the chief anesthesiologist failed three written tests for

board certification. His failure was revealed in a sworn deposition in which the doctor, originally trained in Poland, challenged a private hospital for terminating his privileges.

An Egypt-trained radiologist at the Springfield hospital was fired last year after other staff doctors complained repeatedly to officials about his marginal performance.

Of the 129 medical and surgical physicians allotted to the nation's 53 federal prisons, about 60 percent are members of the Public Health Service or National Health Service Corps. The majority of these are "payback" doctors, fresh out of nationally known residency programs and obligated to work for a time in federal service in return for the government's financing of their

CARE AND PUNISH: (NT) MEDICINE BEHIND BA'

Some inmates harmed rather than healed

medical training.

Some of their colleagues in the prison health corps, however, joined the Bureau of Prisons after foreign medical training or upon retirement from private practices.

Facing the doctors behind prison bars are staggering workloads, low pay and the ever-present stress of caring for some of society's most notorious felons — all of which drive many competent physicians from the prison system, say current and former prison doctors.

The disparity in qualifications among the remaining doctors, they say, creates a dramatically inconsistent system of health care. Frighteningly for inmates, it is also a "take it or leave it" system in which captive patients seldom are afforded second opinions — even if they offer to pay out of their own pockets.

And neither the prison bureaucracy nor the courts traditionally have acted upon prisoners' complaints. Critics say that bureaucrats are under intense pressure to hold on to whatever doctors they can; prisoners' attorneys know that prison doctors, as federal employees, are protected from malpractice claims.

Top-ranking prison officials prefer to focus not on the records of individual doctors but on the prison's critical shortage of medical professionals — which they attribute to an undesired image of prison medicine as second-rate.

"Until we improve the image, we have difficulty in being sufficient staff on board, which creates increasing pressure on existing staff, which drives existing staff away, which makes more pressure on existing staff," said Dr. Kenneth Montagu, the Bureau of Prisons' medical director. "It goes round and round and round like that."

Acknowledging that "we're not all perfect," Dr. Montagu said prison doctors, like their counterparts in private practice, could be plotted on a bell-shaped curve. Some would be worse than average, some better than average and, he hopes, the majority of them are in the middle.

However, critics of prison health care, both from inside and outside the system, say the damage done by bungling doctors goes far beyond their individual medical mistakes. For, the critics say, the persistence of inept physicians within the prisons is just one more reason that top-notch doctors shun prison medicine.

Over a year, *The Dallas Morning News* interviewed more than 130 people, including current and former prison doctors, private doctors, guards, inmates, attorneys and regulators. The Bureau of Prisons declined requests under the federal Freedom of Information Act for information on the medical backgrounds and training of its staff doctors.

The *News* also examined medical records and nearly 900 lawsuits filed in the three states where major prison hospitals are located. The research revealed case after case in which the performance of prison

doctors was criticized in legal actions or by their peers.

'Gross Incompetence'

The Commonwealth of Kentucky State Board of Medical Licensure in June 1988 suspended Dr. Paul A. Pichardo's license to practice medicine for one year. A hearing examiner determined that the doctor's treatment of inmate Jose Serra constituted "gross incompetence, gross ignorance, gross negligence and/or malpractice."

Mr. Serra, now 68, was serving a three-year sentence for a drug conviction at the Federal Correctional Institution in Lexington where his right leg was amputated in 1983. Mr. Serra, a diabetic, previously had undergone the amputation of his left

leg. The amputation of his remaining leg came after Dr. Pichardo failed to respond quickly to evidence of a blooded artery in Mr. Serra's remaining leg, according to a judgment in a civil lawsuit. The government paid Mr. Serra \$625,000 in damages.

Again, in 1985, the government settled, with another of Dr. Pichardo's patients in the Lexington prison. Former inmate Danny Ransert, who had been serving a seven-year sentence on a tax conviction, received \$455,000 after he was blinded by a prescription ordered by Dr. Pichardo.

Testimony showed that Dr. Pichardo had prescribed dosages of the medication in greater amounts

TROUBLE IN THE O.R.: A NURSE'S JOURNAL



This diary, kept by a member of the surgical staff at the U.S. Medical Center for Federal Prisoners in Springfield, Mo., details selected events that occurred there.

July 20, 1987: "(During) jejunostomy (intestinal surgery) to (patient), used two jejunostomy tubes. One was inadvertently broken during attempted placement by Dr. Michael Swenson. I was stuck with a hypo needle in the left index finger . . . by Dr. Swenson."

July 24, 1987: "The operating permit was incorrect on patient Jerry Davis. The surgical schedule and the permit indicated left (ear), when in fact his records all indicate right. . . . Note Davis had a piece of tape under his left ear reading "other ear." Aug. 11, 1987: "Dr. Swenson was found sneezing while the intercom . . . I turned the intercom off."

Oct. 5, 1987: "Spoke to (registered nurse Chris) Thomas, shift supervisor, regarding Dr. Swenson's (upcoming) exploratory laparoscopy (abdominal surgery), and expressed my concern about the potential for problems."

Oct. 8, 1987: "Exploratory laparoscopy/gastric resection (by) Dr. Swenson on Alvin Young started at 8:03 a.m., lasted until 4:23 p.m. Transfused 5 units of blood."

Oct. 7, 1987: "Staff all say they are still tired, and they look and act it. . . . Met with Ms. Tyndal (nursing director) regarding Dr. Swenson. I addressed the operating room staff's concern over big cases by Dr. Swenson and asked about our rights to refuse to do big cases with him."

Oct. 5, 1987: "Spoke with (Associate Warden James) Holland and (Health Systems Administrator W.C.) Gaunce regarding Dr. Swenson's practice. He emphasized strong concerns about his indecisiveness and inexperience."

Oct. 18, 1987: "I submitted a 'duty assignment objection' form today to go on record as working under protest with Dr. Swenson."

Nov. 2, 1987: "(Three other operating room staffers) filled out objection to duty assignment (forms) regarding working with Dr. Swenson. (A fourth employee) indicates he also is concerned about working with Dr. Swenson, but being a probationary employee, doesn't want to be open to retribution."

Dec. 2, 1987: "Dr. Swenson attempts a liver (biopsy) in recovery room; subsequently, patient has dyspnea (difficulty in breathing), expectorates bright red blood, and Dr. Swenson inserts a chest tube. I went over and asked if I could help. He said, 'No, we don't need anything.' I asked him specifically if he needed suture, and he said, 'OK, yeah, we could use some 2-0 silk.'"

June 16, 1988: "We (operating room) are staffed at 77 percent of authorized strength; 64 percent trained at this time."

Aug. 6, 1988: "Morning report . . . from staff includes: short staffing and 'bullying' by the doctors' causing frustration and resentment."

SOURCE: Former member of surgical team at USMCFP, Springfield, Mo.

The Dallas Morning News-Karen Shann

CARE AND PUNISH, INT: MEDICINE BEHIND BA

than recommended by its manufacturer and that, despite the pharmaceutical company's recommendation that eye tests be administered to detect potential side effects, the tests were not ordered.

A judge ruled that negligence by the prison medical staff caused Mr. Ranseri's blindness. However, the judge, noting that Mr. Ranseri's attorney had not proved "deliberate indifference" by Dr. Pichardo, dismissed the Mexico-trained doctor from personal liability.

"I had a crime and I paid for it," said Mr. Ranseri, who now lives in Florida. "I'm still paying for it. You can't buy new eyes. . . It's the worst sentence you could put on a human being."

A prison task force formed in July 1986 to evaluate Dr. Pichardo's performance found that he "appears to be significantly weak in general medicine."

Dr. Pichardo, then 65, was allowed to resign in August 1986 after the task force presented its report, sources told *The News*. When he applied a year later to reacquire his medical license, according to board records, Dr. Pichardo omitted that he had lost his privileges to practice at the prison hospital.

The Kentucky licensing board withheld Dr. Pichardo's license, ruling that he could reapply this summer — if he obtains post-graduate training in medicine and takes a medical exam.

Dr. Pichardo declined to comment on the case. "I don't see the point of going over it again," he said. "It's very unfair after going through so much pain and so much trouble."

'Devastating effects'

In a rare move, the U.S. Parole Commission released Ronnie Holley in April 1988 after he had served

only two years of his five-year sentence for falsifying gun records.

Commissioners concluded that the 35-year-old South Texas carpenter had suffered "extreme family hardship" and "devastating effects, both mentally and physically" as a result of an operation by Dr. Leland E. Wetzel, the chief of surgery at the Bureau of Prisons' flagship hospital.

Mr. Holley left the prison medical center at Springfield, Mo., impotent and deformed.

Dr. John D. McConnell, an assistant professor of urology at Southwestern Medical School in Dallas who examined Mr. Holley after his operation, concluded in a letter to Mr. Holley's attorney that "the surgery in Springfield was handled in a very haphazard and an almost negligent manner."

Dr. McConnell, who later performed reconstructive surgery on Mr. Holley over a two-year period, wrote that while Mr. Holley appeared to have suffered from a chronic inflammatory condition, the incision on his penis shaft was "totally unacceptable" and almost always results in cosmetic and functional deformity.

"In my opinion," Dr. McConnell wrote, "the patient should have had surgery performed by a board certified urologist who had experience in this area."

Dr. Wetzel, 64, is a 1947 graduate of the University of Health Sciences, College of Osteopathic Medicine, at Kansas City, Mo. The American Medical Association said it is unaware of any board certification obtained by Dr. Wetzel, but the American College of Osteopathic Surgery said Dr. Wetzel was certified as a fellow in 1969.

Dr. Wetzel, in a letter to *The News*, said he declined to be interviewed. "I object to discussing any

past or present patient with anyone unless they have proper authority," he wrote.

Mr. Holley, who returned to his home in Edinburg, said the results of the surgery still haunt him.

"Every time I go to the bathroom or shower, what do you think I think about?" Mr. Holley asked. "Springfield."

Dr. Wetzel's work also has been criticized by doctors who have worked alongside him.

Dr. Dante Landucci, a board-certified internist and former staff member at Springfield, was so concerned about Dr. Wetzel's treatment of an inmate last year that he complained to Warden Al Turner.

The inmate, who had a history of chest pain, was admitted by Dr. Wetzel on May 18, 1988, from the U.S. Penitentiary at Leavenworth, Kan. According to a memo written by Dr. Landucci, Dr. Wetzel failed to recognize that the patient was suffering "significant problems, and that his condition was unstable." He neither asked for consultation nor alerted doctors on the next shift that the patient was seriously ill.

Dr. Landucci noted that the inmate suffered a heart attack the next day and recovered "only after protracted resuscitation."

Dr. William Hardman, a board-certified vascular surgeon who practices privately in Springfield and consults at the prison hospital, said Dr. Wetzel's knowledge and techniques are perilously outdated.

"He has no business operating," Dr. Hardman said.

Privileges limited

On Feb. 7, 1987, Lawrence Mason, a 40-year-old convicted bank robber, died at Springfield as Dr. Michael Swanson unsuccessfully tried to force a breathing tube down his



Ronnie Holley, rendered impotent by a surgical procedure gone awry at the U.S. Medical Center for Federal Prisoners

in Springfield, Mo., managed to impregnate his wife with the assistance of further medical treatment.

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

already damaged windpipe.

The previous day, according to some members of the scrub team, the 41-year-old osteopathic surgeon, who did not complete his residency in thoracic surgery, mistakenly had stapled and cut Mr. Manson's airway during a lung operation. Dr. Swanson's error turned a relatively common four-hour operation into a bloody nine-hour ordeal.

About four months later, on June 24, according to members of the operating team, Dr. Swanson ran into trouble during a vascular graft procedure on 49-year-old Vincent Flythe, who was serving six years for drug possession.

Dr. Swanson called for a vascular surgeon from a downtown Springfield hospital to help complete the procedure. Although surgeons say it is not uncommon for a doctor to need help during complicated vascular procedures, Dr. Swanson's colleagues said they became concerned when his postoperative report failed to mention the other doctor's assistance. Operating room staffers said they refused to sign the report until Dr. Swanson — on the third submission — mentioned the outside help.

After the Manson and Flythe surgeries, authorities asked that Dr. Swanson's work be reviewed by Dr. Philip Bernatz, a board-certified thoracic surgeon who joined the prison hospital staff in Rochester, Minn., after retirement from the Mayo Clinic. After their review, officials said, Dr. Swanson's privileges for thoracic and vascular surgery were rescinded.

When Dr. Swanson joined the prison hospital in September 1986, he had completed a three-year general surgery residency and one year of a three-year residency in thoracic and cardiovascular surgery, records show.

"We were told, and he told us, that he had had training and could do these cases, and we took his word for it," said Dr. James Clawson, the 45-year-old doctor who became chief of health programs at Springfield after retiring from private practice.

Dr. Clawson, asked about the apparent inconsistency in investigating other doctors' backgrounds but not verifying Dr. Swanson's credentials, replied: "I can say there is any consistency."

Warden Turner and Dr. Clawson defended Dr. Swanson's performance and suggested that other staffers' complaints — which include formal protests filed by several members of the operating room team — may stem from "personality differences."

Dr. Swanson declined interview requests from The News, but said in a letter that "the press is not a proper forum for critique or judgment (sic) of the medical profession."

"...the overwhelming majority of patients," he wrote, "have excellent care and good surgical results."

Death called needless

Benjamin Firth's heart problems were so severe, according to his attorney, that Mr. Firth's commercial driver's license had been suspended for medical reasons.

When Mr. Firth, a former truck driver who was convicted of trans-



Pictured above are three members of the surgical team at the U.S. Medical Center for Federal Prisoners in Springfield, Mo. Standing are Dr. Leland Wetzel (left) and Dr. Michael Swanson. Seated is Dr. James Clawson.

porting cocaine, died in the Springfield prison hospital on Sept. 18, 1988, one doctor of the hospital's staff believed he didn't have to die.

That doctor wrote a memo criticizing the inmate's physician, who was also his own supervisor Dr. E. Stanley Nelson.

"As a consequence of my review of the case of Benjamin Firth, I have come to the conclusion that his death was preventable," Dr. Landucci wrote on Oct. 25 to Dr. Clawson, the hospital's highest-ranking doctor.

Dr. Landucci pointed out that Dr. Nelson had not prescribed nitroglycerin for treatment of Mr. Firth's chest pains, even though the inmate was suspected of having coronary artery disease.

"I'm not aware that the concerns about this man's medical care have ever been formally considered by the medical staff in keeping with practices of quality assurance," Dr. Landucci said.

The News, in oral and written requests, attempted to interview Dr. Nelson but received no response. Prison officials said that Dr. Nelson refused to be interviewed. Reached at home late Sunday, Dr. Nelson refused to be interviewed.

Dr. Nelson, 59, is chief of medicine at Springfield. He graduated in 1954 from the College of Osteopathic Medicine and Surgery in Des Moines, Iowa, now known as the University of Osteopathic Medicine and

Health Sciences. The American Osteopathic Association lists his specialty as internal medicine.

Dr. Landucci also criticized Dr. Nelson for leaving an AIDS patient in so much pain that the inmate attempted suicide.

"He was grossly ignored by Nelson," Dr. Landucci said in an interview. "This guy was suffering so much that he tried to kill himself."

Dr. Landucci, who was substituting for Dr. Nelson on the day of the attempted suicide, said he rushed to the patient's room. The inmate lived and was returned to Dr. Nelson's care the following day.

Peers spurn doctor

When Dr. George Corvin came in the prison hospital in Springfield in April 1987 as chief anesthesiologist, he had just defended himself in the death of one of his former patients, Sandra K. Stout of Warrensburg, Mo.

Ms. Stout's survivors had sued the Poland-born and trained doctor for wrongful death, saying that Ms. Stout had died because she hadn't received enough oxygen during her 1986 surgery.

Dr. Corvin denied any liability in Ms. Stout's death; the state's licensing agency shows no record of disciplinary action against him.

The Stout case was settled out of court. Dr. Corvin's insurance company, he said in a deposition later, paid \$750,000.

Dr. Corvin's deposition came in a

CARE AND PUNISHMENT: MEDICINE BEHIND BARS.

lawsuit he filed against Western Missouri Medical Center in Warrensburg, alleging he had been wrongly dismissed.

Before immigrating to the United States in 1961, he said in the deposition, he had practiced obstetrics and gynecology. He also testified that although he completed a year of general medicine and two years of anesthesiology at Allegheny General Hospital in Pittsburgh, he has failed the written test for board certification in anesthesiology three times.

He explained in the deposition that he had problems with the language of the exam: "understanding the questions, maybe." Colleagues at the prison hospital in Springfield say he speaks with a heavy Polish accent and sometimes has difficulty making himself understood and understanding others.

Dr. Clawson said that Dr. Corvin has performed good work at the prison hospital. Just because doctors lack board certification, Dr. Clawson said, "doesn't mean that they're not competent physicians."

At least two surgeons in private practice in Springfield said they would not work with Dr. Corvin as a result of his work at Cox Medical Center in the mid-1960s, but they declined to give specifics. Both asked that their names not be used.

Dr. Clawson, the hospital's chief doctor, said "one of the surgeons in town filled me in" on complaints about the anesthesiologist's work before his hiring at the prison. He termed the complaints "ridiculous."

"I had a crime and I paid for it. I'm still paying for it. You can't buy new eyes."

—Danny Ranieri, former inmate/patient at Springfield

"I've looked into this very thoroughly, and I knew all about the case in Warrensburg and it was an unfortunate happenstance and yes, I'm aware of that," Dr. Clawson said in an interview.

Dr. Corvin and his attorney didn't respond to requests for interviews by *The News*.

Egyptian doctor fired

Some staff members at Springfield had professional problems with Dr. Michel K. Mikhail, an Egyptian-trained radiologist, almost from the day he was hired.

Staffers who frequently used radiology services told *The News* that Dr. Mikhail, 39, refused to make firm diagnoses and was incapable of performing even simple diagnostic procedures.

"On a simple chest X-ray, he'd say it could be tuberculosis, cystic tumor

or something else," said one staffer who worked with Dr. Mikhail. "The doctors would call and say, 'Which one is it?' He'd never commit himself to a diagnosis."

In a Jan. 18, 1967, memo to Dr. Clawson and W.C. Geunee, the health services administrator, Dr. Landucci, then a staff internist at Springfield, complained about Dr. Mikhail.

"Initially, difficulties arose with the interpretation of simple studies. In particular, chest X-rays were frequently noted to have 'possible' anomalies ... and repeat studies were often recommended."

"I have also been disturbed by the need to do without certain studies which I feel should be in the purview of an individual working in this capacity," Dr. Landucci wrote.

In one instance, Dr. Landucci said, an inmate patient was forced to wait a month for a test that Dr. Mikhail initially said he did not know how to perform but later promised to learn. Dr. Landucci sent the patient to an outside facility for the test, the memo said.

"Dr. Clawson defended him for the longest time," said one staffer. "Dr. Clawson hired him."

Dr. Mikhail, a 1957 graduate of the University of Cairo, was dismissed months after he started. Warden Turner, who dismissed him, said Dr. Mikhail did "not measure up to the standards that we have here."

Dr. Mikhail declined to comment.



The Dallas Morning News, William Snyder

Dr. E. Stanley Nelson, a doctor at the U.S. Medical Center for Federal Prisoners in

Springfield, Mo., questions an unidentified patient under his care.

The Dallas Morning News

Monday, Jan

1978

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

Physical therapist Gene Diullo wraps the stump of inmate Nick Pirillo's leg. Mr. Pirillo lost the lower part of his leg to gangrene that developed when he was in a U.S. prison hospital in Loretto, Pa.



The Dallas Morning News: William Snyder

Doctors battle image, conditions

Many feel isolated from peers

By Olive Talley

Staff Writer of The Boston Evening Free Press

Dr. Timothy Barth was the chief of medicine at a new and imposing high-rise in downtown Manhattan. Yet, when he attended meetings of the New York County Medical Society, he frequently sat alone.

"I had never felt so medically isolated in all my life," he said.

Dr. Barth's practice was at the Metropolitan Correctional Center, a federal jail for prisoners awaiting trial or transportation to prisons. As a prison doctor, he was shunned by peers.

That was 10 years ago, but little has changed to improve the "bloody apron, bare light bulb" image of doctors who practice behind bars.

"I'm a prison physician," Dr. Barth said. "I'm unaware of any prison health care service that doesn't have some problems. But for that matter, I don't know of any hospital — no matter how big or important — that doesn't have problems."

Problems behind bars, according to those who have practiced there, are unlike those in any other medical environment.

Federal prison doctors face staggering patient loads: inmates that range between \$30,000 and \$75,000; distrustful and often dangerous patients and conflicts with prison wardens who place higher priorities on security than medical care.

Federal prison doctors, for example, frequently find themselves trying to provide good care to patients who distrust them.

"The greatest anxiety anyone has in jail from the moment they walk in that door is that they're going to die in jail or that something is going to happen to them that will substantially alter . . . or shorten the time they have left once they get out," said Dr. Barth, who worked in federal prisons in New York, Kentucky and Michigan before joining the Michigan state prison system.

"That anxiety is pervasive and colors any contact you have with any kind of medical person," he said.

Although some inmates are ap-

preciative of the care they receive, others manipulate (inmates to get drugs, to avoid work or to win transfers, Dr. Barth said.

Prisoners have pulled out their own stitches, removed casts and dressings, and refused therapy, he said, because of the paranoia and pressures that permeate the prison environment.

Inmates, according to Dr. Jay Kramer, chief of medicine at the Federal Correctional Institution in Lexington, Ky., lump doctors in the same category as guards and wardens, whom they call "police."

"You walk an ethical tightrope," said Dr. Kramer. "In most situations in medicine, the physician is the patient's advocate. Here, at times, you have to be an adversary, or at least a perceived one."

Doctors also complain they are limited by the paramilitary structure of the prisons and are forced to take orders from security personnel who have no medical training.

"They don't offer support and you have to work with people who are frequently your boss who not only know nothing about medical care, but who shouldn't be in management," Dr. Barth said.

Dr. Dayle Robson, a doctor formerly assigned to the Federal Correctional Institution at Ashland, Ky., said the paranoia in prison creates an "us vs. them" mentality that interferes with good medicine.

When he was assigned to the medium-security prison in 1984, Dr. Robson said, he was told "not to trust anyone outside the prison system, and especially doctors outside the prison system, who were to be considered enemies."

"The only way they know to run a prison is to keep everyone afraid and insecure," said Dr. Robson. "I don't think the people in charge of the Bureau of Prisons know what it really means to put the patient Number 1."

When Dr. Robson publicly criticized the facility, he was forced to resign.

"I refused to be dishonest about the quality of medical care at the prison," he said.

The Dallas Morning News, Tuesday, June 27, 1967

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

coaters has an impact on the efficiency with which our care is provided," said Dr. Kenneth Mortimer. He said he has directed the agency's staff to conduct "a major analysis" of its transportation system.

"Obviously, if there is an emergency that needs to be transported, and it takes three weeks to get somebody into a medical center, the logistical problem translates into a quality-of-care of problem. No question."

In Mr. Masor's case, the autopsy listed the cause of death as sudden cardiac death, probably due to a rhythm abnormality. The report also noted that the inmate suffered from hardening of the arteries to his heart.

But the Masor's family, in a lawsuit pending against the federal government, claims that the 13-hour trip by prison bus aggravated Mr. Masor's condition and caused his death.

"His medical history... clearly indicated such busting would cause Mr. Masor's death," according to the family's legal claim. "Further, Mr. Masor personally requested alternate transport due to his fear that the bus trip would kill him."

Dr. Martha Grogan, chief of medicine at the prison hospital in Rochester, confirmed in an interview with *The Dallas Morning News* that Mr. Masor and several other inmates who arrived on the bus transfer were "very ill," and several died within a couple of weeks.

However, the doctor said, Mr. Masor's heart had deteriorated so badly that he could have died at any time; she said she doubted that "there's any way you could directly attribute it (his death) to the bus trip."

In another case, the U.S. Justice Department in December paid a North Carolina woman an undisclosed amount to settle a lawsuit after her son died in 1966 of asphyxiation shortly after he had been transferred by bus to the Federal Correctional Institution at Butte, N.C.

Wladis Harris, 31, had complained to transfer officers that he needed to use the restroom, according to witnesses. A guard wrapped an Ace bandage around Mr. Harris' head, then taped over the bandage with duct tape, leaving a small hole for the prisoner's nose. A prison physician's assistant was asked to examine Mr. Harris after he gasped for help. Witnesses said the physician's assistant suggested that the guard cut a small hole in the tape over Mr. Harris' mouth.

Minutes after the guard used a knife to cut the hole, witnesses said, Mr. Harris collapsed, jerking and writhing as he sat chained in the bus. Attempts to resuscitate him failed. The guard, Lt. Jerry A. Dale, pleaded guilty in court and was sentenced to nine years in prison.

Last year, the Bureau of Prisons transferred 30,643 inmates — some of them several times — for a total of 92,000 transfers. Most transfers are for court appearances, security or disciplinary reasons and medical care, officials said.

The bureau transfers prisoners with its own fleet of 31 specially de-

signed buses, or two Boeing 727 jets it shares with the U.S. Marshals Service and, in emergencies, by private aircraft charter.

Decisions on how and where to transport ill inmates are made by a chain of command that begins with doctors and ends with the "medical designator," a non-physician at bureau headquarters in Washington. Factors include cost of treatment, the kind of treatment required, se-

curity concerns, available bed space and transportation costs.

Dr. Joseph Boggs, a clinical psychologist and former warden of the Federal Medical Center at Rochester, said patients who arrived at his prison hospital by special air ambulance usually withstood the trip with few ill effects. Those who arrive on buses, however, didn't always do so well.

The problem... is when they

CLEMENT MESSINO'S ORDEAL



In July 1967, prisoner Clement Messino, who had undergone quadruple bypass surgery in 1962 after a heart attack, was bused from the prison at Springfield, Mo., to the prison at Sandstone, Minn. Within months, he was shipped back to Springfield, again by bus.

According to his account, detailed in a lawsuit against the Bureau of Prisons, what should have been a 1,300-mile journey covered more than 2,700 miles and caused him to have another heart attack.

1 July, 1967: Mr. Messino is ordered to leave Springfield after his doctor — allegedly working from another inmate's medical chart — determines that he is not ill. Mr. Messino asks not to be transferred by bus, but his request is denied.

2 July 16: The bus leaves Springfield. Rather than traveling north to Minnesota, it travels southwest to the prison in El Reno, Okla. Mr. Messino spends the night in a cell where the temperature reaches more than 100 degrees.

3 July 11-14: The bus takes Mr. Messino from El Reno to the prison in Terre Haute, Ind., passing through Springfield. During these days at Terre Haute, Mr. Messino hyperventilates and is given oxygen.

4 July 15, 1967: During a 10-hour bus trip from Terre Haute to Sandstone, the temperature tops 100 degrees. When Mr. Messino reaches Sandstone, a doctor determines that he is suffering from severe heart disease.

5 September, 1967: Mr. Messino's medical condition prompts Sandstone officials to ship him back to Springfield. He petitions for a medical furlough to seek private treatment. The request is refused. He asks doctors to see that he is not shipped by bus, but his plea fails.

6 Sept. 18: Mr. Messino is shackled and placed on a bus that takes him to the prison at Oxford, Wis.

7 Sept. 16: The bus takes Mr. Messino to a prison in Chicago, where he complains of chest pains. He is forced to spend six hours on the bus parked outside the prison.

8 Sept. 17: Mr. Messino is bused to Terre Haute.

9 Sept. 18: While locked up in "administrative segregation" at Terre Haute, Mr. Messino suffers a heart attack. He is taken to a hospital in the community, where he spends approximately a week in intensive care.

10 About Sept. 26: An ambulance carries Mr. Messino from Terre Haute to the prison hospital at Springfield, where he continues to suffer chest pains, dizzy spells and shortness of breath.

SOURCE: Clement Messino vs. U.S. Prison, warden, Federal Correctional Center, Springfield, Mo.

The Dallas Morning News Staff Bureau

By Arthur J. Brown, Staff Writer

CARE AND PUNISHMENT: MEDICINE BEHIND BARS



Arno Turnond (left in photo) and Donald Meschino help a 70-year-old inmate into a van for a trip from the U.S. Medical Center for Federal Prisoners in Springfield, Mo., to a hospital for treatment unavailable at the medical center.

get into the bureau transportation system which deals with a lot of people," said Dr. Bogan, now assigned to bureau headquarters in Washington.

"It's possible for them to get lost through the cracks."

Among the captive passengers handcuffed and shackled in their seats, transportation by prison bus is known as "the route" or "the circuit." Inmates who say the process is punitive call bus transfers "diesel therapy."

Whatever the terminology, the bus shuttle that links the nation's 55 federal prisons can be a marathon of 400-mile days, stale sandwiches and short nights in county jails. Depending on the destinations of the various inmates and the order in which the government decides to deliver them, a trip that would be 300 miles by a direct route can stretch into weeks or even months.

"It is the pit," said David Irvin, a former federal magistrate and now a criminal defense lawyer in Lexington, Ky. "You can literally disappear for months."

"A way that Uncle Sam gets back at those who rock the boat is that they put you on the bus," Mr. Irvin said. "From what I have heard, this is a practiced method of retaliation."

"You spend the night in county jails. You are not allowed to take any clothes with you. You wind up in the worst of all worlds."

Women have reported bleeding on themselves and their seats during bus transfers and airlifts because they were not provided sanitary napkins or tampons. In some cases, they say, they have been teased by male prisoners traveling alongside them.

Prisoners say even the least ardent of bus transfers can be taxing to the health.

For the sick, they can be deadly.

John Devine, a former municipal judge in Cook County, Ill., was 56 when he died at the U.S. Medical Center for Federal Prisoners in Springfield.

His attorney believes Mr. Devine's death was hastened by a long and debilitating bus transfer.

Mr. Devine, sentenced to 10 years in the Operation Greyhound investigation into corruption in Cook County courts, had requested a transfer from the Federal Correctional Institute in Lexington to the Oxford, Wis. facility, closer to his family.

"Ultimately John got the transfer, but unfortunately, he was taken by way of Buffalo, N.Y., to all these Podunk counties by bus," Chicago lawyer Jeffrey Steinbeck said in an interview.

Mr. Devine, a recovering alcoholic who suffered liver problems, wound up on "the circuit" for nearly two months, Mr. Steinbeck said.

"It wound up they lost track of him . . . He had been en route on one of these 55-56 day debacles," the lawyer said. "I regard that as torture."

When the former judge finally got to Oxford, "someone in intake took one look at him and determined that he was an extremely sick man," Mr. Steinbeck said.

Mr. Devine was shuttled onto yet another bus. This time, the trip to the prison hospital at Springfield, Mo., was direct.

Within a day, a doctor had diagnosed Mr. Devine's condition as liver cancer.

Mr. Steinbeck quickly won a federal court order allowing his client to be furloughed and treated at Northwestern Memorial Hospital in Chicago.

A prison doctor told the attorney that the former judge was too weak and could not leave Springfield. Mr. Devine died two weeks later, on April 2, 1967, in the federal prison hospital.

"The point is that if they had not sent him away for a few months, he might have been at least made comfortable and seen his family and done some things," Mr. Steinbeck said.

Mr. Steinbeck said he chose not to sue over Mr. Devine's death because the doctor who treated his client in his final days, Dr. David Kimmel, deserved "a medal, not a lawsuit." Dr. Kimmel left Springfield in 1967 after completing a tour of duty with the Public Health Service.

For the sick, they can be deadly.

The same month that Mr. Devine died, Clement Meschino, a 42-year-old former Chicago police officer, turned himself in to the hospital in Springfield to begin a three-year sentence for his role in an auto parts theft ring.

Five months later, Mr. Meschino — a heart patient who had undergone a quadruple bypass operation after a massive heart attack in 1962 — suffered a heart attack during a bus transfer.

Mr. Steinbeck filed an emergency writ of habeas corpus in federal court in Springfield, asking for a medical furlough for his client to obtain medical care from his own doctors at his own expense.

"The deliberately indifferent treatment which he has received from the Bureau of Prisons threatens to turn his three-year sentence into a death sentence," the attorney wrote in the Oct. 9, 1967, pleading. The care given Mr. Meschino was "no adequate," he wrote, "that it shocks the conscience and offends fundamental notions of decency and fairness."

The attorney said a doctor at Springfield had attempted to treat his client's heart condition "while working under another inmate's medical chart." During Mr. Meschino's three-month stay at Springfield, he was called to the hospital only twice for a treadmill test and for a brief chat with a doctor. Prison doctors, according to Mr. Steinbeck, ultimately concluded that nothing was wrong with Mr. Meschino.

After complaining about his care, Mr. Meschino was transferred to a federal prison in Sandstone, Minn.

"Meschino, shackled at the hand and foot, left Springfield on July 10, 1967, travelling in a prison bus," the legal brief stated. "The trip to Sandstone was circular."

Though Sandstone lies about 650 miles north of Springfield, Mr. Meschino traveled by way of St. Louis, Mo. (285 miles southwest); Terre Haute, Ind. (700 miles northeast); and finally to Sandstone (500 miles northwest).

On several occasions during the six-day odyssey, which included three days of incarceration at Terre Haute, temperatures aboard the bus and in the lockups soared past 100 degrees. The final leg of the trip, from Terre Haute to Sandstone, took more than 19 hours.

At Sandstone, a doctor determined that Mr. Meschino had a severe heart condition and needed treatment at a prison medical facility.

"Meschino, fearful that another long and indirect bus trip could result in him having another heart attack, attempted to force such a dangerous trip," Mr. Steinbeck wrote.

The inmate sought a medical furlough to fly to Chicago for treatment by his own doctor at his own expense. But his pleas "fell on deaf ears," and Meschino was ordered transferred out of Sandstone in the same manner in which he came," Mr. Steinbeck wrote.

On Sept. 15, 1967, a shackled Mr. Meschino began another dose of diesel therapy.

From Sandstone, he traveled more than 200 miles southeast to Oxford, Wis. The next day, he rode 200 miles to Chicago, where, ironically, he was within a few miles of his personal physicians.

The Dallas Morning News Tuesday, 27, 1968

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

A marshal (left) frisks an inmate before the prisoner is loaded onto a plane. Frisks of each inmate are mandatory, as are the handcuffs and chains such as those piled in front of prison buses (above). Prisoners transported by plane or bus are shackled by their hands and feet to restrict movement.



The Dallas Morning News

Trust's Leading Newspaper

4 with the Dallas Morning News

Dallas, Texas, Tuesday, June 27, 1980

5 Sections

40 25 Cents

Enduring 'diesel therapy'

Long, rigorous trips for care take toll on seriously ill inmates

Third of six parts

By Olive Talley

and two of The Dallas Morning News

© 1980 The Dallas Morning News

August Masorek had been hospitalized for several weeks in the U.S. Medical Center for Federal Prisoners in Springfield, Mo., when Cuban inmates rioted and seized control of federal prisons in Atlanta and Oakdale, La.

As part of a contingency plan to open beds for inmates they feared would be injured in the



riots, prison officials ordered Mr. Masorek and about 40 other inmates moved from the hospital.

In November 1967, Mr. Masorek, a 64-year-old with chronic heart disease, was shackled by his wrists and ankles and chained to his seat for a 300-mile trip by bus to the Federal Medical Center in Rochester, Minn.

On Nov. 24, 1967, within 24 hours of his arrival at the Rochester hospital, Mr. Masorek —

Photo page

7A

a World War II veteran sentenced to 10 years for fraud — died of "sudden cardiac death."

Interviews with inmates and medical staff members, and internal prison documents obtained by The Dallas Morning News, show that dozens of ill prisoners are transferred when their condition is unstable. Some arrive at prison hospitals acutely ill because of the hardships of the bus trips, during which medications sometimes is withheld.

In addition, inmates commonly arrive without their medical records, forcing doctors to provide care without knowing the patient's history or recent diagnosis.

The medical director of the U.S. Bureau of Prisons describes as "a major problem" the task of transferring seriously ill inmates from the nation's far-flung network of federal prisons to the bureau's three primary medical centers.

"The logistical problem of getting inmates into and out of some of our more specialized



The Dallas Morning News William Snyder

Chains secure a prisoner as he waits to be transferred by plane to a federal facility. Inmate wears handcuffs and leg chains during the entire trip.

CARE AND PUNISH...ANTI-MEDICINE BEHIND BA. J

While at Chicago's Metropolitan Correctional Center, a federal lockup, he complained that he was experiencing chest pain. Nevertheless, he was ordered to remain in a bus parked outside the center for six hours without medical treatment, the lawsuit alleged.

Four days after he started his trip in Sanderson, Mr. Messine arrived back at Terre Haute.

At 5 p.m. on Sept. 19, 1967, "while locked in the hole," Mr. Messine suffered a heart attack.

He was rushed to Terre Haute Regional Hospital, where, according to the lawsuit, he remained in intensive care for about a week. A doctor at the hospital said the heart attack had damaged Mr. Messine's heart tissue so much that he needed a transplant, the lawsuit said.

Again, Mr. Messine was returned to Springfield — this time by ambulance.

Mr. Messine's care did not improve once he got to Springfield, Mr. Steinbeck alleged. In the month after his heart attack, Mr. Messine was seen by a doctor only once for 10 minutes; he was taken off medication prescribed by the Terre Haute physician, and X-rays from Terre Haute were not transferred to Springfield, the lawsuit claimed.

Prison officials, who sent Mr. Messine to a private cardiologist for an examination, argued in their response to the suit that his condition had stabilized.

On Feb. 5, 1968 — four months after the case was filed — U.S. Magistrate James England denied Mr. Messine's request for a medical furlough, saying the government has shown him no "deliberate indifference."

U.S. District Judge William Collinson upheld that ruling a month later.

Meanwhile, another federal judge was arguing strenuously in Mr. Messine's behalf. In a letter to the U.S. Parole Commission, dated Nov. 12, 1967, Judge Prentice Marshall of Chicago urged the panel to consider Mr. Messine's health in his application for parole.

"As a cardiac bypass patient myself, I am convinced that Mr. Messine is very ill and needs the care of his physician at Northwestern Memorial Hospital in Chicago," wrote Judge Marshall, who had previously reduced Mr. Messine's sentence from four to three years because of his heart condition.

In February 1968, shortly before Judge Collinson issued his final order in the case, Judge Marshall wrote an appeal to his colleagues on the bench.

"We are convinced that defendant is a very sick man," wrote Judge Marshall. "We are also convinced that the wise and humane course would be for the Bureau of Prisons to grant him a furlough so that he can be examined by the cardiologist of his choice. But we lack jurisdiction in order that relief."

Mr. Messine was transferred to Oxford, where Mr. Steinbeck said his condition has stabilized.

Prison officials deny that inmates have died as a result of transfers, but prison doctors point to some examples in which patients came close.

"There was a guy transferred from Leavenworth (Kan.) to Springfield who had diffuse bleeding around the brain, and they put him in an ambulance... on a 300-mile drive," said Dr. Dante Landucci, a board-certified internist who worked at the prison hospital in Springfield from June 1967 until December 1968.

"They should have put him in a helicopter or hospitalized him locally," said Dr. Landucci, who recently was promoted to chief of health programs at the Bureau of Prisons' Metropolitan Detention Center in Los Angeles.

Dr. Landucci outlined the problems with that transfer and two others from the U.S. Penitentiary at Leavenworth in a July 15, 1968, memo to Dr. Ken Spangler, deputy chief of health programs at Springfield.

"This is a reminder: Staff at Leavenworth should be strongly encouraged that patients for emergency transfer ought to be given serious consideration for such by helicopter rather than ground carrier. This would have been especially appropriate in the recent cases of two patients with myocardial infarction (heart attack) and (bleeding around the brain)."

Often, the problem lies not with the mode of transportation, but with the time it takes correctional officers to move the inmates.

"The problem is the uncertainty of the length of time of transfers," said Dr. Grogan, the chief medical officer at Rochester.

"It is definitely far from ideal and the biggest problem that we get is when we're talking to a doctor in Florida and he wants to send on a patient," she said. "He doesn't really know what's going to happen to the patient when he leaves, where exactly he's going to go, how long he'll be in holdover status, what kind of attention he'll get there and when will he get to Rochester."

Physicians also complain that, too frequently, medical records are not transferred with the patient, and doctors have no information on which to undertake treatment.

Bureau of Prisons policy prevents inmates from having access to their entire medical files. Only certain information, such as the patient's history and test results, can be viewed. And at times, inmates have needed court orders to get that information. As a result, they are not allowed to carry their files with them. Correctional officers are supposed to cart the files along with the inmates, but often that does not happen, according to correctional officers and medical staffers.

Such was the fate of Glenn Packoff, who died 12 hours after arriving at the Springfield prison hospital April 26, 1968.

Doctors — who had no forewarn-

ing of his arrival — suspected that the 26-year-old suffered from a massive blood infection, but they had little to go on, because Mr. Packoff's medical records did not accompany him, according to one doctor who asked not to be named. During the transfer, guards said, he complained of stomach pains.

"He was breathing so hard, he couldn't talk," the physician said. "He was real scared."

Mr. Packoff, a convicted drug offender, had been in a county jail in California and then on an airlift for four days.

"I figured out by the few papers that accompanied him that he had been seen by a doctor four days prior, just before leaving," the doctor said.

"They transported him when he shouldn't have been transported and they didn't stop at a hospital when he started looking sicker and sicker," the doctor said. "I'm not sure anything could have been done at the point we got him."

An autopsy revealed a diseased liver.

Dr. Landucci documented similar problems in an Oct. 21, 1968, memo to an associate warden at Springfield.

"This week alone, I have seen two consecutive, supposedly emergency admissions for whom there are absolutely NO current records, despite their having only recently been released from community hospitals," the doctor wrote.

In another memo dated four days later, Dr. Landucci pointed out yet another example: "(The patient) arrived with so little documentation that it was impossible to know where he came from, let alone what was wrong with him. Five calendar days, since his arrival, have failed to be sufficient time for his papers to catch up with him."

Another doctor formerly on staff at the Springfield prison hospital recalled a 1968 incident in which a heart patient was transferred from the Federal Correctional Institute at Terminal Island, Calif.

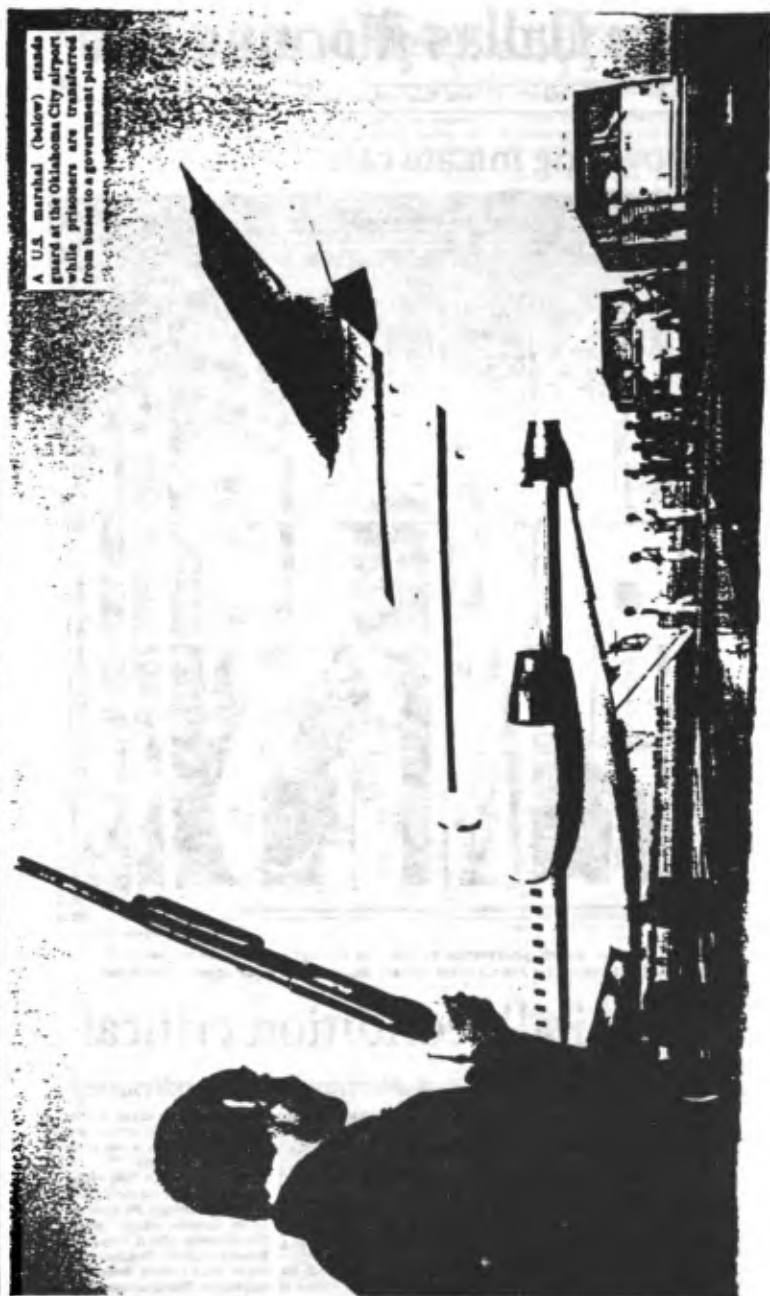
"He got here OK, but his catheterization films didn't get here," the physician said. "I waited more than a week. He was having bad chest pain every night... but I couldn't get them to send the things."

Because the doctor was afraid the patient might suffer a heart attack and die before the test results arrived, he called in a cardiologist to repeat the test.

"We did another cath and we charged the BOP \$1,000 and then took him to surgery the next day. He had open heart surgery... (After recovery) we just sent him back to Terminal Island. I just hope he got there. He knows he really came close."

AP Wirephoto Service Photo Tuesday, June 23, 1968

CARE AND PUNISHMENT: MEDICINE BEHIND BARS



A U.S. marshal (below) stands guard at the Oklahoma City airport while prisoners are transferred from buses to a government plane.

The Dallas Morning News

Truest Leading Newspaper

Printed by the Dallas Morning News

Dallas, Texas, Wednesday, June 23, 1960

13 Sections

47¢

***** 25 Cents

Providing inmate care



The Dallas Morning News: William Bricker

Larry Brett is a staff pharmacist at the U.S. Medical Center for Federal Prisoners

in Springfield, Mo., the largest of the U.S. Bureau of Prisons' medical facilities.

Hospital's condition critical

Prisons' flagship facility is overcrowded and understaffed

Fourth of six parts
By Olive Talley

Staff Writer of The Dallas Morning News
© 1960 The Dallas Morning News

SPRINGFIELD, Mo. — It looks like a perfect place for healing.

Once the private estate of a prominent Springfield family, the U.S. Medical Center for Federal Prisoners sits amid 257 gently rolling acres of manicured lawns, tree-lined drives and stately red brick buildings.

Even its polished brass railings echo the boast of Warden Al



Mayo can help hospital. 21A

Turner: "We are pretty much the flagship for the federal Bureau of Prisons' medical system."

Indeed, with 1,163 beds — 306 for medical and surgical cases —

Springfield is the largest hospital in the federal prison network. It is also one of the oldest prisons in the system, opened in 1903.

Through its halls have walked some of the most notorious criminals of this century: Joe Bonanno, Carlos Marcello, Joseph Valachi, Vito Genovese, Mickey Cohen and Robert Stroud, the "Bird Man of Alcatraz." More recently, Hustler publisher Larry Flynt spent time here.

But despite its billing as the prison system's leading acute-care Please see FLAGSHIP on Page 24A.

By Dallas Morning News Staff Writer, June 25, 1978

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

Flagship hospital overcrowded, understaffed

hospital, its captive patients derisively call it the "Death House" and file hundreds of lawsuits each year.

"We do not have a clientele that is happy to be here, nor do we have a clientele that is going to be agreeable with the level of treatment in a good percentage of cases," said Warden Turner.

"In our business, you're constantly playing defense. Anybody can make an allegation."

Some of the toughest allegations are from the medical professionals who have practiced behind the walls of Springfield. Many describe a hospital long racked by overcrowding, staffing shortages, weak management and uneven medical care. Those deficiencies have been documented by internal hospital records and independent audits.

"It is stated that we are to meet the standard of care in the community, but we do so only as much as is convenient," said Dr. Dante Landucci, former staff internist at Springfield who recently was transferred to the Los Angeles Metropolitan Detention Center.

Doctors and nurses, meanwhile, say the growth and aging of the inmate population and the advent of AIDS have stretched them beyond their capabilities. "Please do something . . . before there is a death," one doctor begged her supervisors last year.

"Are the physicians overworked and underpaid? Are they worked pretty hard? Yes they are," said Warden Turner. He said, however, that by recognizing the procedures by which patients are admitted, administrators have averted a crisis.

If crisis has been averted, some members of the medical staff say, vestiges of major problems linger inside the prison.

In a rare display of public criticism, physicians and nurses inside and outside the hospital have questioned the competence of some prison staff doctors.

The only independent body to monitor the hospital — the Joint Commission on the Accreditation of Health Care Organizations — criticized Springfield last year for neglecting evaluations of staffs' competence and patient care, among other deficiencies.

"There was no action . . . to improve patient care over the last period of years," according to a summary of the 1988 auditors' report.

Prison officials, who long touted the medical center as a model prison hospital, say the pressures created by rising costs and a larger and older population have forced them to re-think Springfield's mission — and, indeed, their whole approach to medical care for prisoners.

"We're not a tertiary care (highly specialized) institution, and we're not a full-service hospital," Dr. James Clewson, Springfield's chief of health programs, said in a recent interview.

A year-long investigation by The Dallas Morning News, which included interviews with key members of Springfield's medical staff, found serious deficiencies in Springfield's operations.

⑥ The commission on accreditation, whose approval is necessary for private hospitals to receive federal Medicare payments, last year placed several contingencies on Springfield's accreditation.

The Bureau of Prisons denied a request under the federal Freedom of Information Act for copies of the 1983 and 1988 accreditation reports. The hospital accreditation commission told Springfield officials that administrators may "choose to make it available to the various publics you serve." The News obtained the reports, however, from prison sources who requested anonymity.

"There should be somebody who is evaluating the care in this hospital on a monthly basis," the summary said. "You (physicians) do have some Friday morning meetings which review patient care, but there are no conclusions drawn from them."

Although Springfield has been in operation 34 years, its first set of staff bylaws setting out the responsibilities and organization of medical staff was drafted in late 1967 — only weeks before the commission team arrived for its inspection, staffers said.

Warden Turner did not address

U.S. MEDICAL CENTER FOR FEDERAL PRISONERS Springfield, Ill.

History: Oldest and largest federal medical facility, built in 1933.

Mission: Flagship medical center, providing acute care and surgical treatment for male prisoners of all security levels.

1988 budget: \$31 million*

1988 medical budget: \$13.7 million*

Total beds: 1,183

Hospital beds (medical and surgical): 508

Staffing	Authorized	Employed
Doctors (medical / surgical)	18	10
Nurses	124	113
Physician's assistants	11	10
Total medical personnel	234**	204

* Projected figures for fiscal year.

** Includes recently authorized positions.

SOURCE: U.S. Bureau of Prisons

The Dallas Morning News

The 1988 report criticized the hospital for poor organization, "routine justification" of all surgical procedures, inadequate monitoring and evaluation of medical staff, and failure to implement quality assurance programs. The survey also found that the use of blood and blood components was not adequately monitored, depriving administrators of an important tool for recognizing surgical errors.

In addition, the report said, the medical center set forth no policy for assigning doctors duties based on the hospital's specific needs or on each doctor's proven capabilities.

Dr. Clewson, who is responsible for granting doctors' privileges, bristled at many of the commission's conclusions, calling the inspectors' medical things in "hot-headedness and leather jackets."

He said he resented many of the requirements imposed by the agency and found them irrelevant to prison hospitals. But he acknowledged that Springfield had no choice but to comply for the sake of its image.

Reviewing the hospital's quality assurance, the independent accreditation committee's three auditors — a doctor, a nurse and an administrator — lauded Springfield for an "excellent" quality assurance plan.

"But it is not followed," they wrote in a preliminary summary of their findings, which they presented to the hospital's staff on Jan. 8, 1988.

The auditors, noting only one medical staff meeting in 1987, made their accreditation contingent on doctors holding more frequent meetings to discuss and evaluate patient care.

specific findings of the accreditation panel, but he said the hospital "corrected what the joint commission pointed out needed to be corrected."

"The joint commission came back in again (in January 1988) for their following survey and they lifted all the contingencies," he said. "We're fully accredited."

⑥ Springfield is severely understaffed.

Five of 15 positions for medical and surgical doctors are unfilled, according to prison officials. Early this year, within a four-week period, two of the hospital's three internists requested transfers, they said, because of their concerns about quality of care at the institution.

Eleven of 134 nursing positions are empty. Most of those vacancies have existed for at least a year, documents show.

Before a recent reorganization, staff internists routinely carried a caseload of more than 100 hospitalized patients.

In a meeting in June 1988 to address increasing concerns among internists, Dr. Landucci, now chief of health programs at the Los Angeles facility, said two physicians remarked that they intentionally prolonged the stay of certain patients "in order to delay the arrival of new admissions."

Warden Turner said the hospital is "strapped" but not to the point that patients are suffering.

"Obviously, if the numbers (of patients) had kept increasing at the rate they were, and if our count had continued to go up beyond 1,300, like it was (in December), certainly I

The Dallas Morning News "What's Hot," June 22, 1988

CARE AND PUNISHMENT MEDICINE BEHIND BA.

think we would have reached a point that we would not have been able to take care of that," Warden Turner said.

Springfield last year was overcrowded by as much as 20 percent above its rated capacity. Its population currently is below capacity, largely because the shortage of medical staff has forced administrators to curtail the number of patients they accept, Warden Turner said.

Nurses, particularly on the 4 p.m. to 8 a.m. shifts, say that within the last year they have been pressured to provide care for more patients than they can handle. By December, they said, the shortage had become so acute that administrators closed the operating room for three weeks and reassigned surgical nurses to other parts of the institution. A five-bed unit for patients requiring intensive

a nursing care also was closed and remains empty.

Mandatory double shifts were imposed, and the entire nursing staff was redistributed. Several nurses quit, saying they no longer were willing to tolerate working conditions that jeopardized patient care and made them liable in inmate lawsuits.

"The system doesn't care about you," said one registered nurse with six years' experience at Springfield. "You're a body to fill a slot." The nurse asked not to be named for fear of retribution from prison authorities.

The staffing shortage also resulted in the most highly trained nurses being assigned to supervisory posts rather than caring for the most acutely ill patients, the accreditation commission noted.

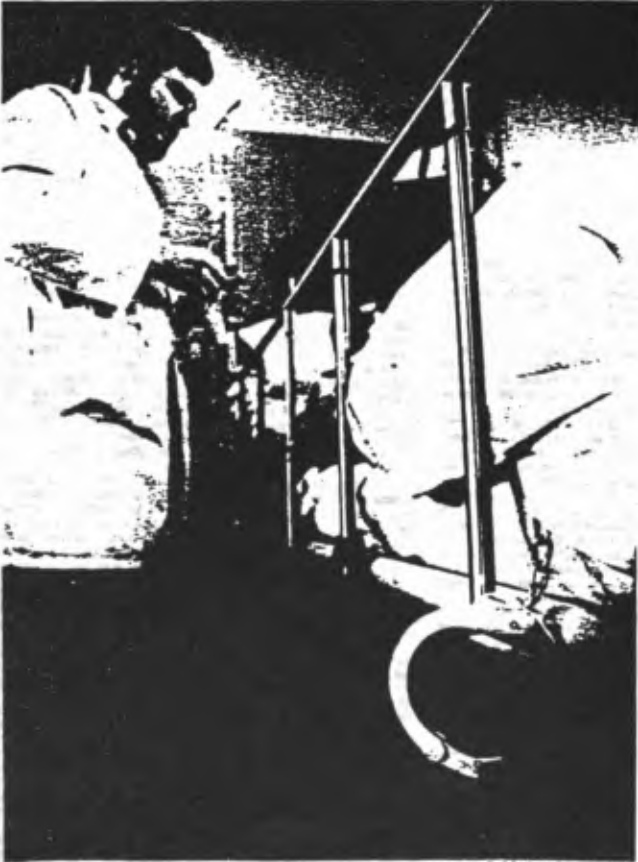
■ Nearly a dozen nurses inter-

viewed by The News said they often have been asked to perform medical work beyond their training.

"As (physician) assistants and nurses are frequently told to evaluate patients at a level beyond their level of expertise, after which physicians do not take the time to check their work thoroughly," Dr. Landucci wrote in a Dec. 22, 1988, memo to Warden Turner. "This leads to poor care of the inmates."

■ Contrary to policy and official statements, inmates have suffered delays in getting care once they arrive at Springfield. Medical evaluations are not always performed within 24 hours of their arrival.

The 1988 accreditation survey found that about one-third of patients whose records they reviewed had not been evaluated within 24 hours of their arrival. Many inmates



The Dallas Morning News William Joseph

Dr. Kenneth Spangler, deputy chief of health programs at the U.S. Medical Center for Federal Prisoners in Springfield, Mo., checks on an inmate in the recovery room.

Because the inmate is considered a high security risk, he is chained to his bed. A guard also will remain in his room until the inmate is returned to his cell.

The Dallas Morning News, Wed., October 23, 1985

CARE AND PUNISH... IN THE MEDICINE BEHIND BA. J

probably will be treated at hospitals near the prisons where they're assigned, rather than being transferred to Springfield.

Springfield, Warden Turner said, will be left to handle high-security inmates whom officials do not want out in the community and who require long hospital stays, including AIDS patients.

Such changes should ease the burden on the medical staff, but they do not address one of the staff's most pervasive complaints: that Dr. Clawson is, in the words of one nurse, a "weak" manager who turns a blind eye to bumbling by doctors and other deficiencies.

"Dr. Clawson is a nice old gentleman, but he doesn't... deal with the problems out here," said the regis-

tered nurse, who used to work at the prison hospital.

"This whole facility seems to be out of control from an administrative standpoint," said another registered nurse who has worked at the Medical Center for seven years.

Dr. Clawson said he has attempted to do "the right thing at the right time."

"All I can say is that there have been complaints brought to me, but we certainly have handled them in, we thought, the best ways to provide the best care to the patients," he said.

"If I haven't pleased all the nurses, it might be because that I haven't done what they've wanted me to do."

Ineffective leadership, coupled

with low pay, danger, understaffing and overcrowding, have demoralized staff morale and created an environment dominated by, in the words of one longtime registered nurse, "complete negativity."

"What further robs the system of virtue," recently retired prison guard Ivan Paul wrote Bureau of Prisons Director Mike Quinlan, "is the fact that in spite of the millions of dollars that we spend on these criminals for medical care, much of that money is wasted because of incompetence on the part of some medical staff... and the refusal of officials to hold them accountable."

Minnesota center aided by Mayo ties

By Olive Talley

As news of the state prison system's new medical center from

ROCHESTER, Minn. — When Ireland's deputy prime minister, Brian Lemmon, was told last month that he needed a liver transplant, he flew 4,250 miles across the Atlantic to undergo the operation at the famed Mayo Clinic.

When convicted Louisiana crime boss Carlos Marcello needed treatment for Alzheimer's disease, he traveled just two miles down the road to get the same quality of care.

The 75-year-old Mr. Marcello was assigned to the Federal Medical Center at Rochester, the U.S. Bureau of Prisons' newest — and according to insiders and outsiders — best prison hospital. The cornerstone of that distinction lies in its affiliation with the world-renowned Mayo Clinic.

"Of all the prison doctors I've dealt with, that staff is outstanding," said John J. Cleary, a former federal defender in San Diego and longtime critic of medical care in federal prisons.

"They're a voice crying in the wilderness," he said. "It was started to be progressive and it started off with the Mayo connection. That's the one (federal medical center) that is working now."

FMC Rochester works so well that top prison administrators caution that its standards are impossible to duplicate throughout the system; 115 inmates beg for transfers there; and doctors at other prison hospitals point to its enviable doctor-patient ratios as proof that the facility receives preferential treatment within the Bureau of Prisons.

Surrounded by an affluent residential neighborhood and shaded by groves of trees, the newest hospital for federal inmates once was known as Rochester State Hospital, a mental institution until it was converted in 1983 by the federal prison system.

Central to that decision was the hospital's proximity to one of the world's most respected hospitals. "The biggest strength we have is our relationship with the Mayo Clinic," said Dr. Joseph Bogan, a clinical psychologist and former warden of the prison hospital.

Rochester, the bureau's sixth medical center, was designed to handle the more complex, difficult and unusual medical and surgical cases among the prison system's nearly 50,000 inmates, Dr. Bogan said.

The hospital has come a long way since its rocky start. Residents lost court battles to keep federal prisoners from living in their neighborhood.

The federal government, after paying \$14 million for the site, spent millions more on equipment and renovations to meet Mayo's exacting standards.

"When I first got here, there were no patients in the hospital, the operating room was not completely renovated and there were a lot of problems," said Dr. Martha Grogan, a Mayo graduate who joined the prison staff in 1987 and later became its top medical officer. "There were no systems or procedures developed."

The staff was short of nurses, sometimes with a ratio of one nurse to 40 patients, Dr. Grogan said.

A turning point at the hospital occurred in late 1987, when Cuban inmates rioted at federal prisons in Atlanta and Oakdale, La. In anticipation of receiving casualties, authorities at the U.S. Medical Center for Federal Prisoners at Springfield, Mo., cleared some of its beds by moving prisoners to Rochester.

"We literally went from having 40 patients to having 80 to 85 in one day," Dr. Grogan said. "Several of those patients were very ill. They came on a long bus ride. One patient died within 24 hours... several other patients died within a couple of weeks."

Dr. Grogan said the chaos triggered by those events "made for a very difficult year" but forced Rochester to become a full-service hospital.

In the past year, Dr. Grogan said, the hospital has brought its operating room, intensive care unit, laboratory and X-ray units into full swing.

As they struggled to amass equipment and staff, prison officials also had to win over some Mayo Clinic doctors who weren't eager to treat patients behind prison bars or to accept prisoners into their clinic.

A Mayo task force made it clear to prison officials that the clinic would compromise neither the quality of its care nor its image, said Ken Johansson, a Mayo administrator.

FEDERAL MEDICAL CENTER
Rochester, Minn.

History: Former state mental hospital acquired by the Bureau of Prisons in 1984; opened in September 1985.

Mission: Designed to treat very difficult or complex medical and surgical cases. Serves mainly low- to mid-security inmates; most inmates are male, but about half a dozen women have been treated.

1988 budget: \$20.4 million*
1989 medical budget: \$9.6 million*

Total beds: 600
Hospital beds (medical and surgical): 150

Staffing	Authorized	Employed
Doctors (medical/surgical)	8	8
Nurses	80	60
Physician's assistants	12	12
Total medical staff	140	130

*Projected figures for the fiscal year
SOURCE: U.S. Bureau of Prisons

The Dallas Morning News

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

have said, and staffers have confirmed that patients have waited days — sometimes weeks — to be seen by overworked doctors.

Inmate Pete Galtano suffered acute respiratory arrest late on Aug. 14, 1986, and, according to medical staff, probably would have died had a nurse not performed mouth-to-mouth resuscitation.

Mr. Galtano had been at the prison hospital for eight days without receiving a thorough evaluation.

Dr. Peter Albright, the physician to whom the inmate was assigned, said in an Aug. 19 memo that Mr. Galtano was among 10 or more patients "who have been here for a number of days without being seen, due to simple lack of enough physician time."

"This is just the kind of event that can be expected to increase in frequency, with inevitable casualties, if the system of receiving patients to this institution is not changed to reflect how many people we can realistically take care of at any one time," wrote Dr. Albright, a board-certified internist.

"Please do something about this situation before there is a death. The medical physicians and nurses are developing a siege mentality, refusing from an emergency to the point it is not good for the patients, the institution, or us."

"The bureau always says, 'If your client is serious enough, we're going to send him to Springfield,'" said John J. Cleary, a former federal defender in San Diego. "Is that for help or hurt?"

Although administrators until recently had characterized Springfield as a big-city medical center, one registered nurse who has worked there six years said, "We're a small-town hospital."

There are no doctors at the hospital after 4 p.m. or on weekends unless they are called in on an emergency. One doctor is designated as the physician on call. The rotation, medical staffers say, includes eight psychiatrists who normally do not treat medical cases.

"A 1,000-bed hospital in the private world would be geared up for going 24 hours a day," said Dr. William Hardman, a general surgeon who works as a consultant at the prison hospital.

The laboratory, pharmacy, surgery and radiology departments also shut down at night and on weekends — leading medical staff to complaints of delays in getting proper treatment for inmates. Sometimes, doctors say, they are compelled to transfer acutely ill patients to community hospitals, although the transfers can bring them into conflict with prison administrators.

Dr. Albright, for example, was reprimanded for transferring inmate Nick Pirillo to a downtown Springfield hospital on Friday, Oct. 24, 1986. At the time, the 67-year-old diagnosed diabetic had served only six weeks of his 15-month sentence on a gambling conviction. Mr. Pirillo had arrived at the prison hospital on Thursday night, but was not seen until Friday when Dr. Albright diagnosed a "large, foul-smelling area of black gangrene on his foot."

Concluding that Mr. Pirillo might require immediate surgery — which he could not get at the prison hospital until Monday — Dr. Albright ordered him transferred to St. John's Regional Medical Center in downtown Springfield. The inmate underwent surgery there the following day, and eventually a portion of his leg was amputated.

Dr. Clawson, the prison's chief doctor, scolded Dr. Albright in a November 1986 memo: "Your actions resulted in an inmate being transferred downtown . . . when there was no immediate need. You thereby unnecessarily breached security of the inmate, while also unnecessarily jeopardized the welfare of the escort staff."

Dr. Albright argued, however, that the real problem was the lack of full-time staffing at the prison and the administration's attempt to intimidate doctors who called attention to the hospital's deficiencies.

"My investigative and therapeutic choices (at Springfield) . . . are limited and I have been squeaked too many times, since I arrived here, between the needs of the patients, and the inability of the institution to meet those needs," Dr. Albright responded.

The no-doctors-on-weekends policy earlier had spawned similar criticism in the case of inmate Eugene Fields, who suffered massive internal bleeding on Friday, Jan. 15, 1987.

According to internal prison memos obtained by The News, Dr. Michael Swanson, a staff surgeon, examined Mr. Fields after the 44-year-old prisoner suddenly began vomiting blood about 2 p.m. Dr. Swanson ordered a blood transfusion and left the institution after giving orders for the patient to be monitored closely, according to the memos.

That evening, in a telephone call with the medical officer on duty, Dr. Garry Johnson, an anesthesiologist, nurses on duty termed Mr. Fields as being unstable and requiring more care than they could provide. Dr. Johnson ordered Mr. Fields, who was serving a 15-year sentence for interstate transportation of stolen securities, transferred downtown.

When he arrived at the downtown hospital that night, Mr. Fields said, the admitting doctor told him and the guards who escorted him: "If you'd have waited five more minutes, you could have dropped him off at the morgue."

"If the nursing staff hadn't intervened," said one registered nurse at Springfield, "he could have died."

Alan Deskis, a registered nurse on duty that night, said Mr. Fields "belonged downtown, but the attending physician didn't want to send him at that time."

"We had to go around the system to get him downtown," Mr. Deskis said.

Dr. Johnson's decision, however, was vehemently criticized by Dr. Swanson, who nearly came to blows with Dr. Johnson over the incident, staffers reported in memos.

Dr. Swanson declined to discuss his treatment of patients with The News.

Dr. Johnson, a Public Health Ser-

vices physician, later was transferred from Springfield to an Indian reservation in New Mexico. He attributes his reassignment to his outspoken criticism of the quality of care offered by the prison hospital; Warden Turner says his performance was substandard.

Two star physicians who have been critical of the care provided at Springfield — Drs. Albright and Lando — have been transferred out of the institution.

Their transfers, Warden Turner said, were for "a variety of reasons which had nothing to do with their competency as physicians." He would not elaborate.

Although the 54 other federal prisons nationwide traditionally have looked to Springfield to provide medical care that the other institutions cannot provide, Springfield in recent years has not had the resources or staff to accommodate such demands.

During the 1986 fiscal year, which ended in October, about 30 percent of the 5,000 prisoners sent to Springfield were treated at community hospitals. The total cost of outside medical care was \$2.3 million, according to figures supplied by the medical center.

Early this year, when hospital administrators closed the operating room and otherwise scrambled to keep their doors open, top prison medical staff from Washington and Kansas City, Mo., huddled with Springfield officials to map out changes.

This spring, the hospital overhauled its entire medical operation and created a new method of screening inmates to better "match the inmate needs with the staff coverage," said Dr. Kenneth Spangler, deputy chief of health programs.

Between December and May, officials said, Springfield reduced its inmate population from 1,169 to 877 and cut from 300 to 149 the number of beds available for patients who are acutely ill or recovering from surgery.

However, staff members say that although the reorganization "may look better on paper," there appear to be as many surgical and acutely ill patients as before.

"They're just playing a shell game," said one registered nurse who asked not to be identified.

The reorganization contrasts with the hospital's mission as described six months earlier by Warden Turner. The warden said he planned to increase staff and equipment at the Bureau of Prisons' "acute care hospital" to provide more in-house services. By May, however, prison officials were playing down the hospital's capabilities and focusing more on the 33 outside specialists who care for inmates.

Dr. Kenneth Mortenson, medical director of the Bureau of Prisons, said the changes are part of a "refinement" of the system in which resources will be reapportioned according to each institution's medical needs.

That means, Warden Turner said, that inmates with short-term medical problems — particularly patients judged not to be security risks —

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

tor and member of the task force.

"As an institution, Mayo wouldn't cotton to any system that is offering inferior care," he said. "We only have one quality of care, and we're going to provide the appropriate level of care for the patient, whoever they are."

It was two years after the first federal prisoners arrived at the Rochester prison unit that the Mayo Clinic signed an operating agreement with prison officials. Eight months later, in November 1967, the first Mayo doctors walked through the metal detectors at the federal prison.

Mayo doctors saw only 30 prisoners that year, and Joe Martin, another Mayo task force member. Last year, 1,394 inmates were treated at Mayo facilities, while 2,398 were seen in prison by Mayo doctors, Mr. Martin said.

Bringing felons into the Mayo Clinic has provided a startling contrast for a medical staff more accustomed to dealing with Minnesota farmers, wealthy retirees and international dignitaries.

In September 1968, prisoner Silvia Baraldini was transferred to Methodist Hospital, one of two Mayo-affiliated hospitals, for a radium implant to treat uterine cancer. The 46-year-old inmate recalled that she was shackled at the ankles, handcuffed at the wrists and rolled in a wheelchair surrounded by five or six shotgun-toting guards.

The guards accompanied Ma Baraldini, sentenced to 41 years for armed robbery, racketeering, conspiracy and criminal contempt, down the halls to the radiology lab.

As a technician calculated the precise dosage of radioactive material for the self-described "political prisoner," Ma Baraldini said, he was shaky and "sweating profusely."

"I said, 'Why are you sweating so much?' and he said, 'Well, I don't like all these guns.'"

"I said, 'Listen, don't worry about this. I'm not going to give you any problems . . . If you don't like it, how do you think it makes me feel?' " Ma Baraldini said.

Dr. Grogan, the prison medical director, said she, too, had to overcome initial fears from security maneuvers.

"If they're downtown . . . they're shackled to the bed and there are two big guards sitting there and you think, 'Oh my God, what did this guy do?' You don't know that he might be a lawyer from Philadelphia, but the rule says he has to have these restraints."

Although prison officials said they're pleased with the quality of care provided by Mayo's physicians, Mayo administrators decline to discuss the work of their prison counterparts.

"I've been out with many (Mayo) physicians back and forth, and they'd say to me, 'That's not the same as the clinic,'" said Mr. Martin. "But what we do out there is what we do down here."

"In general," said Dr. Grogan, "the patients get very good care."

But the so-called general population, or non-medical inmates who

simply are assigned to the facility's work unit, Dr. Grogan said, received "less than ideal" health care until routine sick call procedures were changed recently.

Dr. Bogan points to the relatively small number of lawsuits filed against the institution as evidence that most inmates are satisfied with their medical care.

Staff lawyer Daryl Kozak said only 12 of 131 legal actions filed against the facility since 1965 allege improper medical care.

"Our record has been good as far as litigation is concerned because, generally speaking, the vast majority of our patients are appreciative of the care they receive," Dr. Bogan said.

"This is not true of all of them."

It certainly is not the posture of Sidney Mayley and Anne Henderson Pollard, two inmates waging ongoing court battles against the facility.



Inmate Sidney Mayley, 32, explains how prison doctors removed his left jaw and tissue and blood vessels from his jaw to his shoulder because of cancer. He had complained of a lump on his jaw for several months before he was treated.

The government recently denied an administrative claim filed by Mr. Mayley, a 32-year-old convicted armed robber with a history of recurring cancer on the face, jaw and neck. He accused the Bureau of Prisons of negligent medical treatment over the last four years.

In March 1963 doctors at Springfield removed his lower lip because of cancer.

In September 1965, Mr. Mayley, was transferred to Rochester. Dr. Ian Jackson, the chairman of Mayo's plastic surgery department, recommended that he be checked every three months.

In the summer of 1966, Mr. Mayley said he noticed a lump on the left side of his neck and jaw. He said medical staffers told him it was scar tissue. Records indicate that Mr. Mayley and his family repeatedly sought a biopsy to check for cancer, but none was performed.

Prison officials in December ordered Mr. Mayley transferred to

"general population." At the U.S. Penitentiary in Terre Haute, Ind., Dr. Thomas Perry concluded that the lump on the inmate's jaw was "no emergency." The doctor authorized Mr. Mayley to be housed in the Federal Correctional Institution at El Reno, Okla.

In January 1967, El Reno officials sent Mr. Mayley to a private consultant who recommended a biopsy after noting that the size of the lump on the prisoner's jaw had apparently tripled in six months.

Prison officials in Oklahoma arranged Mr. Mayley's return to Rochester, where, after 10 days of filing complaints, the inmate again was seen by Dr. Jackson at Mayo.

"When I saw him, he had some cancer stuck onto his mandible," said Dr. Jackson, who now works at a Michigan hospital.

"It must have been there for a long time. These things don't grow overnight. It would take weeks or perhaps months to develop."

One day after examining Mr. Mayley, Dr. Jackson canceled his vacation in order to remove a section of Mr. Mayley's jaw as well as tissue and blood vessels from his jaw to his shoulder. The surgery and subsequent radiation therapy left Mr. Mayley severely disfigured.

"Quite honestly, I didn't think he would survive," Dr. Jackson said.

That Mr. Mayley lived also surprised inmates and prison guards, who ran betting pools on his death, the inmate said.

Two months earlier, Dr. Bogan, in a letter denying Mr. Mayley's request for reconstructive surgery, had told Washington officials that there had been "no sign of recurrence of the cancer." One factor weighing against reconstructive surgery, Warden Bogan wrote, was Mr. Mayley's hostility toward his keepers.

"He has constantly complained about his treatment since he has been incarcerated, without adequate reason or justification, in my opinion," Dr. Bogan wrote.

In an interview with *The Dallas Morning News* in February, Dr. Bogan denied Mr. Mayley's allegations of malpractice and said that Mr. Mayley's attitude played no role in his treatment.

"I've got an attitude because of the way I've been treated," said Mr. Mayley, a native of New Orleans. "Look at me and what I've been through. How would you feel?"

Prison doctors have begun reconstructive surgery on Mr. Mayley.

In perhaps the most publicly debated court action involving an inmate's care, Anne Henderson Pollard unsuccessfully argued that she had been denied proper medical treatment.

The 35-year-old woman was sentenced as five years as an accessory in the case of her husband, Jonathan Pollard, who was sentenced to life in prison for passing classified documents to Israeli agents.

Mrs. Pollard alleged that she received poor medical treatment at Rochester.

The Boston Herald, Boston, Mass., June 22, 1972

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

After three days of testimony, a federal magistrate in Minneapolis concluded that Mrs. Pollard, indeed, suffers from serious and painful intestinal and gynecological disorders. The judge further ruled that her problems had been aggravated by Dr. Grogan's hostile treatment of her, including the withholding of painkillers and refusal to treat an eye infection.

However, the magistrate ruled — and the judge agreed — that Mrs. Pollard likely had worsened her plight by being uncooperative and manipulative. The judge ruled in March that the medical center's overall treatment of the inmate did not constitute "cruel and unusual punishment."

Except for Mrs. Pollard and a handful of women prisoners who have come and gone, the second floor of the Rochester prison hospital remains vacant — symbolic, say its detractors, of its failure to shoulder the patient loads that overwhelm its sister prison hospitals.

"I'd love to utilize that facility and take more patients for the Bureau of Prisons," said Dr. Bogan, the former warden, "but we don't have the staffing level to do that, so we don't want to place patients in an unsafe situation."

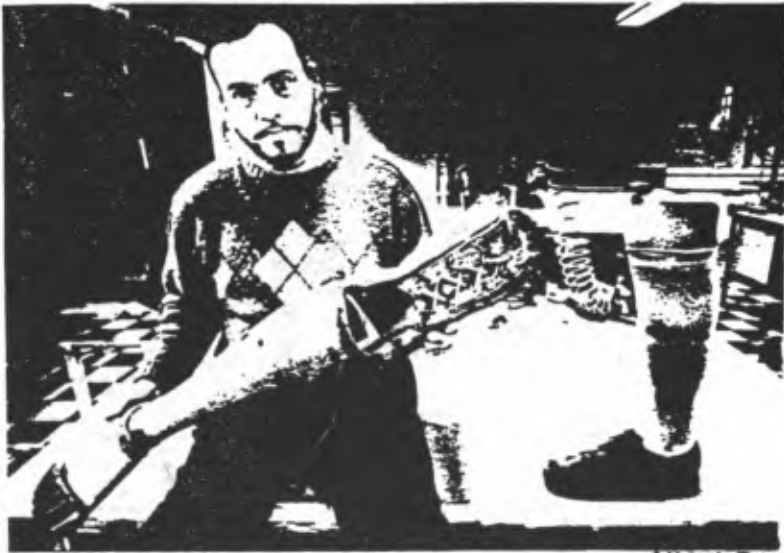
Medical standards must remain high, Dr. Bogan said, for the hospital to maintain its ties with Mayo and to keep its staff intact.

"If there is not proper funding and staffing to handle the workload, we'll lose the excellent people," he said.

Dr. Grogan said Rochester has a better chance of attracting quality doctors because of the Mayo connection and the educational opportunities it offers.

And the prison hospital, she said, is "a fascinating place to work."

"People can feel good about going home at night if they've worked here. They know they've done something worthwhile for someone else."



The Office during Rick Oliver's time

Rick Oliver is in charge of the prosthetics and orthotics department at the U.S. Medical Center for Federal Prison-

ers in Springfield, Mo. He oversees the design and construction of artificial limbs for federal inmates.

The Dallas Morning News

Times: Leading Newspaper in the South-Central States

Dallas, Texas, Thursday, June 20, 1968

6 Sections 47 25 Cents

Female inmates' medical plight

In a male-dominated system, their needs often go unmet

Fifth of six parts

By Olive Talley

Staff Writer of The Dallas Morning News
© 1968 The Dallas Morning News

LEXINGTON, Ky. — Linda Clark was flown to the Federal Correctional Institution here for an emergency hysterectomy after doctors consulting for a remote West Virginia prison discovered cancer in her cervix.

After spending more than two months in the U.S. Bureau of Prisons' major medical facility for women, the 38-year-old Houston woman finally got the operation that West Virginia doctors had deemed an emergency.

Prison officials attributed the delay to the lack of a full-time staff gynecologist at Lexington, which houses about 40 percent of the 3,271 female prisoners who are incarcerated in federal prisons.

Mrs. Clark, sentenced to 25 years for a bank robbery,



The Dallas Morning News
William Joyner

Annie Lewis rests at the prison hospital in Lexington, Ky.



CARE AND PUNISHMENT: MEDICINE BEHIND BARS

Female inmates' medical needs often go unmet

Linda Clark holds her prison-issue rosary while discussing her stay in the Lexington hospital.



berry in Corpus Christi, said a Lexington physician's assistant, who screens and refers patients to doctors, ignored her pleas for immediate care.

"He said, 'You don't understand: There are emergencies that have been here long before you that are still waiting. You're not any more special than anyone else. You'll be seen whenever we get a gynecologist.'"

More than a year after Mrs. Clark's surgery, Lexington — where 1,357 inmates make it the largest women's federal prison and the only hospital exclusively for women — still has no gynecologist on staff.

"I would be the first one to say I'd love to have a full-time gynecologist," said Warden Patrick Kane, who assumed the top post at Lexington last year. "I just can't find one."

The warden said he has tried to fill the vacancy, but competition in the private sector has made it difficult to find a qualified candidate willing to work behind bars for substantially lower pay.

Warden Kane said he has used consulting gynecologists who have "improved dramatically the delivery of routine care and emergency care in the ob/gyn area."

But doctors, lawyers and sociologists who have studied women's health care in prisons suggest that the lack of a full-time gynecologist at the major women's prison facility is symbolic of a larger issue: Women are overlooked in a penal society dominated by men. In the federal system, women account for 7 percent of the inmate population and 23 percent of the staff.

"The major problem with regard to care has to do with the attitude toward women," said Dr. Timothy Barth, who worked as medical director at Lexington from February 1985 to September 1986.

"I felt there was very little positive feeling [toward women]," he said. "I do think that the power relationship between male custodians and women inmates contributes to a lack of concern about women and a victimization of women in institutions."

Washington lawyer Gay Gellhorn represents minimum-security women prisoners in a class-action lawsuit that alleges inequities in Bureau of Prisons facilities and programs. The lawsuit, filed in 1984 by a group of women inmates at the Federal Correctional Institution in Fort Worth, is set for trial in July.

"My research and fact-finding indicates that the federal prison system has a long way to go in delivery of health care to women, both to meet needs and to provide health care at the level it is provided to men," Mr. Gellhorn said.

Warden Kane acknowledges that Lexington does not perform major surgery and relies more on outside consulting physicians, but he said it's unfair to compare his facility with the primary men's hospital in Springfield, Mo., or the Rochester, Minn., facility, which treats women only occasionally.

"We're dealing more with acute care and waiting wounded," Warden Kane said. "They [men's facilities] are dealing more with long-term chronic care, a lot of geriatric cases."

When Mrs. Clark arrived at Lexington in March 1988, Warden Kane said, contract physicians provided only three hours of obstetrics/gynecology care per week and "and sometimes we were lucky to get that."

"I'd have women step me and say, 'I was transferred here from Alderson [the federal prison for women in West Virginia] three months ago for a female problem and I have yet to see a physician.'"

Warden Kane hired Dr. Keith Crocker, a retired Canadian obstetrician, to work full time from November 1988 through February, and again this spring, to help reduce the ob/gyn backlog.

He purchased nearly \$530,000 in ultrasound and mammogram equipment.

And he replaced the previous contract gynecologist with a group of private practitioners in Lexington who provide ob/gyn clinics at the prison hospital one day each week.

Indeed, medical care for Lexington inmates appears to have come a long way since Nov. 25, 1985, when Veronica Chakvuma delivered her baby girl on the floor of the central clinic at the prison, which until last fall was a minimum-security, cased facility. Physicians' assistants had insisted that Ms. Chakvuma was not ready to deliver.

"I begged them to take me to the hospital," Mrs. Chakvuma alleged in a lawsuit she filed after the incident. The pain became so intense that I rolled on the floor, back and forth holding my belly and the baby was born on my coat."

Contrary to information on the birth certificate, prison officials later acknowledged in court documents that the delivery occurred on the floor because the hospital had no bed wide enough to accommodate childbirth. Lexington at the time housed many pregnant inmates and was designated as the main medical facility for female inmates.

Paramedics placed Mrs. Chakvuma's newborn in a cardboard box — the hospital had no baby basket — while the mother, with the placenta still intact, straddled a stretcher in view of male inmates to be taken to Central Recept Hospital. The birth certificate, however, shows that the child was born at the civilian hospital.

A federal court in Lexington in February 1987 dismissed the woman's lawsuit, saying the had failed to prove that prison officials showed "deliberate indifference" to

FEDERAL CORRECTIONAL INSTITUTION
Lexington, Ky.

Hickory, A former U.S. Public Health Service hospital and National Institute of Mental Health hospital converted to a federal prison in 1974.

Milestones: Chief hospital for female offenders; houses women of all security levels.

1988 budget: \$18.9 million
1988 medical budget: \$4.8 million*

Total beds: 1,300

Hospital beds (medical / surgical): 72

Staffings	Authorized	Employed
Doctors (medical/surgical)	9	4
Nurses	28	26
Physician's assistants	11	9
Total medical staff	60	71

*Projected figures for fiscal year

SOURCE: U.S. Bureau of Prisons

The Dallas Morning News, June 25, 1969

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

Before giving birth to a healthy 8-pound, 10-ounce girl on March 17, Delania Logen, an inmate of the Federal Correctional Institution in Lexington, Ky., spent much of her free time napping because her pregnancy made her extremely tired, she said.



her medical needs.

The facts of record show that the unfortunate circumstances complained of were occasioned by the fact that (Mrs. Chakrumsa's) child chose to arrive some six weeks prior to the expected date," wrote U.S. Magistrate Joseph M. Hood, who recommended that the suit be dropped.

Mrs. Chakrumsa alleged that she had been examined four days before she delivered the child and that the consulting obstetrician failed to recognize that she was about to deliver.

Dr. Jay Kramer, chief of medicine at Lexington since June 1968, said care at the prison has improved under Warden Kane's yearlong administration.

"We give good health care," he said. "Sick people we do real well, mainly because if it's anything we can't handle, we just get an ambulance and they go downtown."

Yet Lexington suffers from the same dilemma as its sister hospital, the U.S. Medical Center for Federal Prisoners at Springfield — a shortage of medical staff and tight budgets. At the Kentucky women's facility, two of six positions for medical and surgical doctors are vacant; the budget has dropped by about \$2 million since 1967.

The budget shortfall would come as no surprise to Mr. Geilhorn, the women prisoners' advocate. She points to the prison system's Health Services Manual as proof of the short shrift given women throughout the system.

The handbook spells out guidelines that deal with transverse, glaucoma, distyria and diabetes, but makes no mention of women's gynecological needs. Under the heading of "Special Medical and Allied Problems," the manual devotes only

two of its hundreds of pages to "pregnancy, childbirth, child placement and abortion."

At the recently opened prison for women at Marianna, Fla., inmates complain that they are not offered routine gynecological care, such as pelvic exams, pap smears or breast exams, all of which are recommended annually by private physi-

cians as a means of detecting cancer and other fatal diseases.

"Some of my clients have requested them and have been told the bureau does not provide preventative care," said Mr. Geilhorn.

Dr. Nancy Shaw, a University of California-Santa Cruz sociologist who has studied women's health care issues in prison since the 1970s,



The Dallas Morning News, William Taylor

Patrick Kane, warden of the Federal Correctional Institution in Lexington, Ky., says consulting physicians have "improved dramatically" the delivery of routine and emergency care in obstetrics and gynecology at the prison.

The Dallas Morning News, Feb. 17, 1982, p. 10

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

said women in the federal system often cannot get good gynecological care because they're imprisoned in remote areas where doctors are scarce.

The federal prison for women at Alderson, W.Va., for example, is in the foothills of the Allegheny Mountains, about 30 miles from even a small-town hospital.

Not until Dr. Shew testified before Congress in 1982 did Alderson get its first ambulance. Before that, many pregnant women had complained of not making it to a hospital in time to deliver their babies.

Of all the health concerns encountered by women prisoners, pregnancy is perhaps the most difficult, say advocates of female prisoners' rights. Pregnancy creates not only unique medical demands but also emotional and ethical dilemmas that weigh heavily on prisoner and jailer alike.

At Lexington alone, prison officials expect 45 inmates to give birth this year.

"They're not given the same considerations that you would assume pregnant women in our society are given, and that's minimal things," said Denise Bricker, a legal assistant in the Legal Aid Society, a federal defender unit in Brooklyn, N.Y.

Ms. Bricker's research on pregnant inmates in federal prisons recently permeated a New York judge to reduce the sentence of a pregnant woman convicted on drug charges. Ms. Bricker's report concluded that the stressful and closed environment of federal prisons, coupled with the lack of prenatal care, endangers both the woman and her fetus. The problem is more acute, she said, for drug addicts who often are forced in fed-

**"It may be ok to
punish a woman for
bank fraud by
incarcerating her, but
losing a child is not
part of the sentence."**

—Ellen Barry,

attorney,

San Francisco

eral detention centers to withdraw "cold turkey" without medication.

Both Ms. Bricker and prison officials acknowledge that pregnant women often are viewed by their jailers — particularly men — as troublesome because of their many medical complaints.

"When you're pregnant, you have aches and pains in places where you never realize you had," said Joyce Carmouche, manager of Lexington's Antares Unit, where an average of 30 pregnant inmates are housed. "The importance is magnified by the fact that they think, 'I'm in prison and won't get the proper medical care because I'm in prison.'"

Ellen Barry, a lawyer with the San Francisco-based Legal Services for Prisoners with Children, recently intervened at the coeducational Federal Correctional Institution in Pleasanton, Calif., on behalf of two women with troublesome pregnancies.

"In one case, a woman was placed

in segregation (a small isolation cell) and not seen regularly," said Ms. Barry. "She had gotten pregnant in prison and was being punished."

The prisoner did not lose the baby, but came close, the lawyer said. Ms. Barry said her other client had trouble obtaining treatment for severe cramping and bleeding.

"It may be OK to punish a woman for bank fraud by incarcerating her, but losing a child is not part of the sentence," Ms. Barry said.

Former bank teller Detania Logan, a minimum-security inmate serving four years at Lexington for embezzlement, delivered a healthy 5-pound, 16-ounce girl March 17. But Mrs. Logan's delivery, say critics, illustrates the harsh treatment accorded pregnant women.

"I was handcuffed. . . I had a chain around my waist," Mrs. Logan said, describing her trip from prison to a Lexington hospital. "They put a leg chain on my bed and shackled me to the bed. I had to stay like that for hours."

"I always had a guard with me — a male guard. I wouldn't let him stay in the room when the doctor examined me."

Although the 27-year-old mother had to give up her baby a few days later under prison policy, she at least was able to extract it to her husband. She is among a handful of women inmates whose husbands have not abandoned them and their newborn officials said.

"Once they get in here, they're forgotten by society," said Ms. Carmouche. Others, she said, elect not to keep the babies.

"We have women who do not want the baby, have no resources and tell us that 'When this baby



Inmate Abby McCree gets a look at her baby on a sonogram at the Federal Correctional Institution in Lexington, Ky.

the largest federal prison for women. Lexington has the only prison hospital exclusively for women.

The Dallas Morning News, William Snyder

The Dallas Morning News Thu. June 23, 1987

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

leave this body, it's a Bureau of Prisons' problem — not mine," said Warden Kane.

"We have women who want their child but have no resources. We have women who say they're going to give the child to my grandmother, the only significant other I have out there. She lives in Nome, Alaska, is 104, and doesn't have the money to pick up the baby. Can you get the baby to her?"

Last October, Lexington prison officials returned a newborn child to its father in Bolivia after enlisting the aid of the Bolivian Embassy in Washington, the Bolivian Consulate in Miami and a Bolivian airline.

If the inmate's family does not claim the child at Lexington, Warden Kane said, he must decide whether to spend tax dollars for prison staff to deliver the child cross-country or to find foster care or adoption services.

The warden said he most frequently has chosen to foot the bill for nursery care — in one case \$100,000 in intensive care costs for a premature infant — and tried to place the baby with relatives rather than thrust it upon already overburdened placement services in Lexington.

"What am I going to say? That's not a little convict so I'm not going to pay for it," Warden Kane said. "I think I'm on this legal ice in what I'm doing. But it's what's right."

Some female inmates complain that prison wardens wield too much discretion once they remove infants from their mothers generally within three days or as long as the women require impellishment.

Warden Kane said, however, that he intends to continue placing be-

havioral Eugenea Savodra shows off some of her work in the dental clinic of the Lexington facility. She is learning to be a dental technician and hopes for a career when she is released.



havior as he does now until top prison administrators come up with better alternatives.

"It's like with anything else," Warden Kane said. "You do the best you can given the resources at hand. None of this is easy."



Above, Penny Ochoa, a diabetic inmate at Lexington, injects herself with insulin as physician's assistant Paul Compton watches.

The Dallas Morning News

Texas' Leading Newspaper

and the only morning free

Dallas, Texas, Friday, June 16, 1989

10 Sections

of 8 25 Cents

Prison medical care has few watchdogs

Federal oversight of system is almost nil

Last in a series

By Olive Talley

Staff Writer of The Dallas Morning News

© 1989 The Dallas Morning News

The U.S. Bureau of Prisons, its employees and its image shrouded by walls, bars and razor wire, has spent more than \$400 million on health care for federal prisoners in the last five years — virtually without public scrutiny.

Congress has held no specific hearings and passed no significant legislation addressing the quality of medical treatment inside the nation's 55 federal prisons.

Congress' watchdog, the General Accounting Office, has investigated the labeling of cheese on frozen pizzas and the cost of engine fan blades for the B-1 bomber, but not prison health care.

The Bureau of Prisons' Office of Inspections has taken guards to



task for breaches of security, but has not investigated the backgrounds of the doctors who perform surgery in prison hospitals.

The courts, which have forced prison systems in 46 states — including Texas — to address overcrowding and inhumane conditions, have virtually ignored the systemwide 60 percent overcrowding that has stricken medical services in the federal prisons almost



The Dallas Morning News William Snyder

Small markers designate the pauper's graves of inmates who died

at the U.S. Medical Center for Federal Prisoners in Springfield, Mo.

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

Prison medical system gets little scrutiny

to the breaking point.

And although a growing list of critics, many of them prison employees, charge the system with gross inadequacies, those same critics say the public's attitude that "prisoners deserve whatever they get" hampers attempts to make prison doctors accountable.

"There's nobody who really is going to complain, because it's just another criminal that's stuck," said Jeffrey Steinback, a Chicago attorney who has represented dozens of federal prisoners with medical problems.

In the meantime, according to many of the 150 people interviewed by *The Dallas Morning News*, the sprawling federal system continues to tolerate botched and ineffectual medical treatment of the nation's nearly 50,000 federal inmates.

The *News*, in the yearlong investigation that produced "Care and Punishment: Medicine Behind Bars," discovered a take-it-or-leave-it medical system plagued by:

- Severe overcrowding.
- Critical shortages of doctors, nurses and physician's assistants.
- Inadequate internal review of its own performance.
- Life-threatening delays in transfers of ill inmates to major prison hospitals.

The quality of care given to inmates, said Dr. Kenneth Morrongiue, medical director of the Bureau of Prisons, is "commensurate" with that in the private community. The system, however, could reach "absolute crisis" proportions in coming months if its medical staff's 30 percent vacancy rate worsens, he said.

Although inmates repeatedly have complained about poor care — both to judges and lawmakers — public sympathy has made it easy for public officials to ignore them, critics say.

"Judges, the defense bar, prosecutors and people who have oversight responsibility for the Bureau of Prisons — the Department of Justice —

we all bear the responsibility," Mr. Steinback said.

"As a group, defense lawyers are very poor lobbyists," he said. "The federal public defenders' caseloads are overwhelming; the private bar is interested in making money and not speaking about people who can't pay them, and congressmen are hardly interested. So look at the clinch. Who cares?"

The public's clamor against rising crime rates makes politicians reluctant to press for reforms that could make them appear soft on criminals, said Marcia Stein, president of National Legal Services Inc., a sentencing and parole consulting firm in Atlanta.

"We've got to do away with society's attitude that prisoners deserve whatever they get," said Mr. Stein.

"Congressmen and senators are reluctant because of constituents' personal attitudes about crime and punishment to even deal with something like this," she said. "Anytime you support prisoners' rights — medical or otherwise — you find yourself dead in the water."

Two senior Democratic congressmen responsible for overseeing the Bureau of Prisons — Jack Brooks of Texas, chairman of the House Judiciary Committee, and Robert W. Kastenmeier of Wisconsin, chairman of the subcommittee that monitors the bureau — did not respond to repeated inquiries by *The News* about prison health care.

Lack of public accountability has perpetuated the myth that the federal system is "the Cadillac" of prison health care and "the country club" of prisons, said Washington-based prison reformer Charles Sullivan.

"Because of the overcrowding, which can wreck so many good programs, they're not the model they intend to be," said Mr. Sullivan, lobbyist for Citizens United for the Rehabilitation of Errants (CURE).

"They're very defensive," he said.

"It reminds me of 15 years ago when we looked at the Texas Department of Corrections. ... No one knew there were problems and didn't think there was a need for reform."

Ivan Paul, a 25-year prison guard who recently retired from the U.S. Medical Center for Federal Prisoners in Springfield, Mo., said the Bureau of Prisons' self-imposed secrecy shields medical problems from public exposure.

"The Privacy Act and various other gag rules serve as a convenient shroud to camouflage malfeasance and protect incompetents from public scrutiny and appropriate discipline," Mr. Paul wrote in a recent letter to Bureau of Prisons Director Michael Quinlan.

Rodger Hendricks, president of the American Federation of Government Employees in Springfield, agreed.

"The name of the game is don't tell the public anything," Mr. Hendricks said. "If you're going to tell them anything, make it as positive as possible."

Although most federal agencies have had public information officers for decades, the Bureau of Prisons only last summer created a public affairs department in Washington. The bureau's 14,000 employees now include one who is paid to respond to public queries.

The bureau, which receives an average of 4,000 inquiries a year from the public under the federal Freedom of Information Act, has one legal clerk — not an attorney — who handles all such requests.

The law normally requires governmental agencies to respond to FOIA requests within 30 working days, but the Bureau of Prisons took as long as eight months to answer some inquiries filed by *The News*. Other requests for documents, including internal and external audits of the agency's medical facilities, were denied by the bureau, which alleged that such reports are exempt



Corrections Officer Ted Verfurth delivers lunch to inmates in the high-security area of the U.S. Medical Center for Federal

Prisoners in Springfield, Mo., the U.S. Bureau of Prisons' largest hospital.

CARE AND PUNISHMENT: MEDICINE BEHIND BARS



An inmate at the U.S. Medical Center for Federal Prisoners holds a nurse's hand before a nap. The prisoner, who is serving a

life sentence, has muscular dystrophy.

from public disclosure.

"It's like to see a little more sunshine let into prisons," said John J. Cleary, a San Diego lawyer and former federal defender. "Let's have a little gleam in the federal prisons."

In particular, Mr. Cleary said, he is disturbed by the prison's heavy reliance on physician's assistants — medical personnel who screen patients for doctors but who lack the training to make diagnoses and treat patients.

Medical staffers at several prison hospitals told *The News* that physician's assistants, like nurses, frequently are forced by the shortage of doctors to perform beyond their training.

"Given their limited liability, I'm really frightened by the influence they have, given that there's almost an absolute lack of doctors," Mr. Cleary said.

"You give these people almost an institutional cloak of authority and wind up with what I call a very lazy bureaucrat," he said. "They rationalize doing nothing by saying all the clients are malingerers."

"The answer is Congress," Mr. Cleary said. "There is an overview responsibility to ensure one, qualifications for those who serve, and two, appropriations for the provision of adequate medical coverage; and three, a common-sense attitude that they'll cut down on (law) suits if proper care is given."

The bureau also fails to hold physicians accountable for the care given to each patient, said Dr. Denis Landucci, chief of health programs at the federal Metropolitan Detention Center in Los Angeles.

Peer review was sorely lacking at the Springfield hospital, the bureau's oldest and largest, where he formerly worked as a staff internist, Dr. Landucci said.

"Everything that the medical staff does is unsupervised, unsanctioned. These people have a tacit agreement that they will not criticize each other, and that's the way it works."

"If you evaluated the physicians, if you made them function in a manner that would be expected of them in a community," Dr. Landucci said.

"You do not add to the punishment of incarceration by giving less than adequate medical care. This is the philosophical and legal principle upon which the Bureau of Prisons functions, but there are many physicians who do not abide by that."

Dr. Mortenson said that care — particularly doctors' performance — is closely monitored through in-house quality assurance and peer review programs. Each medical facility undergoes an annual medical audit by a team of professionals from other federal prisons.

"I can see that we could refine it (peer review) and make it even better," said Dr. Mortenson, who became medical director of the system 18 months ago.

He said he is examining several options: having prison doctors reviewed by their peers in nearby communities; organizing peer reviews among prison doctors within certain regions; and developing affiliations with civilian teaching hospitals or medical schools.

Recently, for example, the federal Metropolitan Correctional Center in Chicago signed an agreement with the Chicago College of Osteopathic Medicine for resident doctors to rotate through the prison and the college's hospital to accept prisoners who need outside treatment, Dr. Mortenson said.

Neil B. Shulman, associate professor of medicine at Emory University medical school in Atlanta, said good medicine demands self-criticism.

"I know people in the prison system who are afraid to say anything critical . . . or they'll lose their jobs. I've also spoken to doctors who were so frustrated that they quit," said Dr. Shulman, a former consultant to the Georgia prison system.

Major obstacles to quality prison health care, Dr. Shulman said, are prisoners' inability to choose their

physicians or to get a second opinion.

"It gives too much power to the person who is delivering the care," he said. "You can have one provider who is excellent and another provider who is lousy and if your life is at stake and you have no choice but . . . a lousy doctor, that's an inmate problem."

Inmates have recourse through the courts, Dr. Shulman said, but "the person could well be dead by the time the review process occurs."

The Bureau of Prisons, Dr. Shulman said, "is in desperate need of an outside panel of medical experts to evaluate overall health care on a continual basis."

Mr. Cleary also suggests that inmates be allowed to pay for their own care by doctors of their choice, an option offered in California state prisons.

Only rarely does the Bureau of Prisons approve an inmate's request for a specific doctor — even if the inmate offers to pay out of his own pocket.

The impact of poor medical care, say those close to the prison system, has repercussions that extend beyond inmates.

"There are a lot of people out there whose families are innocent despite the family member's crime," Mr. Shulman, the Atlanta consultant, said, "and they still love that person, and they have the same rights to you and I have to love a person to a whole person."

"And not have them damaged or harmed while in custody serving time."

Mr. Hendricks, the veteran prison guard who heads the employees' union at Springfield, said society needs "to understand that just because you lock somebody up, that's not the end of the story."

"Somebody still has to deal with them."

CARE AND PUNISHMENT: MEDICINE BEHIND BARS

Trucker fears medical 'care' in prison will kill him

By Oliver Talley

Special to The Associated Press

BRIDGEVILLE, Mo. — Rinaldo Bates wrote from a cell in the sound of a low siren. Standing beside his bed, head bowed, a Catholic priest was administering last rites.

"I thought, 'What the hell is going on? You ain't killing me!'" Bates wrote.

The 55-year-old Mr. Bates shuddered at the thought of death earlier this year, but as he lies in an isolation cell, dependent on the constant rush of oxygen from a machine, he fears death can't be far away.

"I pleaded guilty, I came to jail to do my time, but look what they're doing to me," Mr. Bates wrote the U.S. Medical Center for Federal Prisoners in Springfield.

When the New Jersey trucker walked into federal prison in April 1964, he weighed 215 pounds. In six months, he weighed 145 pounds, despite a history of emphysema.

Today, six years later and after a series of life-threatening medical complications, Mr. Bates weighs 141 pounds, is partially paralyzed and suffers chronic breathing problems.

"The guilty I'm no innocent man," Mr. Bates said. "I've been around with drugs I was so glad when they caught me and slammed that door behind me."

"But I didn't plead guilty to be treated like a dog."

Planning with prison officials in March for permission to seek treatment for emphysema, Mr. Bates said he had nearly died three times behind bars because of inadequate medical care.

quite medical care. "I just don't think I am strong enough to go through this," he wrote.

Mr. Bates' battle began in December 1963, eight months after he began his sentence at the U.S. Penitentiary in Lawrenceville, Kan.

"Every time I asked to see a doctor, I go and see whatever you call them," Mr. Bates said. "Each time I go, I get a different doctor. I'm taking seven pills four times a day."

What started as a routine hospitalization for lower back pain and shortness of breath ended as a series of gradually worsening medical setbacks — all of which he blamed on incompetence and neglect.

Mr. Bates, who was admitted with Valium and Dorenone, was found by

ing on the floor of the infirmary with a "small intestine" on his forehead, after apparently striking his head on a lightstand, according to prison records.

A neurological examination was "essentially unremarkable for any new acute injury," the records said, and an examination of his lungs "showed they were clear at the time."

Two days later, however, Mr. Bates' lung condition worsened and an X-ray of his neck and chest showed two vertebrae had been partially fractured. The inmate was transferred first to a nearby Army hospital, then to the University of Kansas Medical Center and finally to the federal prison hospital in Springfield.

Mr. Bates' latest medical setback, a severe neck injury in March 1964 to repair the damaged vertebrae

here, but according to government lawyers, "The surgery did not accomplish all that was hoped." The inmate was released in April 1965, after seven months in prison.

Mr. Bates was found to have severe degenerative arthritis, a personality disorder caused by premises on the spine. Doctors noted that his "prognosis for the future is uncertain."

The surgery did not prevent the inmate from being placed in an administrative appeal unit, where he was treated on the outside, Mr. Bates wrote. "When the court sentenced me, I was sentenced to the CARE and custody of the Bureau of Prisons."

And earlier this year, Mr. Bates was among the inmates who had been given the maximum sentence for tuberculosis at the prison system's

largest hospital.

An inmate who had been Mr. Bates' roommate for two months was asked to sign to be released. "I was told that if I didn't sign, I would have to stay in the hospital."

"Why didn't they just have the decency to come down and give me a hand? I wasn't the only one."

On Feb. 1, prison authorities sent a telegram to Mr. Bates' wife, Rita, notifying her that her husband was "dying."

"Well, I've been in your custody, but far from in your care," Bates wrote. "I've been in your custody for 10 months and I've not been able to get out of the prison."

The Dallas Morning News

Monday, July 17, 1960

Question of neglect

Fellow inmates contend U.S. prisoner who died of tumor was denied care; team to investigate

By Olive Talley

and news of The Dallas Morning News

John Chaffee entered federal prison believing he'd come out a better man.

He told his father that "he wasn't arrested, he was rescued" from a destructive drug habit that led to the bank robberies that landed him behind bars.

In the nearly seven months he spent at the medium-security Federal Correctional Institution near Phoenix, Ariz., the 28-year-old Californian earned an equivalent of a high school diploma and began learning a trade.

On June 12, he was dead. The death certificate said he died from a brain tumor.

But inmates say the once-strapping, 5-foot-10-inch prisoner died of neglect. They said prison medical

CARE AND PUNISHMENT

Medicine behind bars

staffers thought he was faking his illness although he repeatedly begged for care. Since February, prisoners say, Mr. Chaffee had lost 20 pounds, suffered excruciating headaches and could barely walk without stumbling.

"John Chaffee's death was a prolonged, undignified affair that unfolded like a Stephen King horror story," fellow inmate Dennis Martin wrote in a column published recently in the Sunday Punch section of the San Francisco Chronicle.

"Everyone here, including some staff members, are tainted by the shame and guilt of watching it happen," wrote Mr. Martin, 49, a co-Phoenix see TEAM on Page 8A.

Staff insensitive to ailing inmate, prison chief says

But he denies blame in man's death

By Olive Talley

Staff Writer of The Dallas Morning News

Staff members at an Arizona federal prison were insensitive to the medical needs of a 30-year-old inmate who died there last June, but their actions did not cause the inmate's death, the top federal prison official said Friday.

"They had been operating on the belief that this particular inmate, Mr. Chaffee, was not as sick as he thought he was, and that was a mistake," said Michael Quinlan, director of the U.S. Bureau of Prisons.

John Chaffee, 30, died of a brain tumor on June 12 — 10 days after prison officials confined him to an isolation cell in the belief that he was exaggerating his illness. He had complained of severe headaches for weeks.

CARE AND PUNISHMENT

Medicine behind bars

"He was in administrative detention for four days on the mistaken belief by the staff that he was possibly intoxicated when seen walking across the compound," Mr. Quinlan told *The Dallas Morning News* in an interview Friday. "In retrospect, he was not intoxicated but suffering from the effects of this brain tumor."

The day after he was released from isolation, prison doctors confirmed a diagnosis of brain tumor in Mr. Chaffee, a bank robber, Mr. Quinlan said. He was rushed by helicopter from the Federal Correctional Institution near Phoenix. Please see STAFF on Page 37A.

Continued from Page 33A.

to an outside hospital, where he died six days later.

The director's comments represent a rare confirmation of inmate complaints about medical care. He vowed to take steps to prevent similar occurrences in the future.

"We obviously do not sanction or take pride in situations in which our staff is not as sensitive to medical concerns as we would like," he said.

"This case has heightened our concern about those issues, and a combination of things are being planned in terms of sensitivity training," Mr. Quinlan said. He refused to discuss whether any staff members may be disciplined in connection with the case.

Mr. Quinlan said Mr. Chaffee's treatment is an example of a system-wide problem pointed out in a recent consultant's study. Huge patient loads and manipulative inmates have overwhelmed prison doctors and dulled them to some real medical needs, the consultant concluded.

Nonetheless, officials contend that evidence collected by medical and correctional investigators shows that the delayed medical diagnosis and staff treatment did not result in Mr. Chaffee's death, officials said.

"There is no reason to conclude that Mr. Chaffee's death, regrettable as it may be, was due to improper or inadequate treatment by the staff," Mr. Quinlan said in a statement.

"It is very unlikely that he would have lived, even if the tumor had been diagnosed the first day he complained to staff about the headaches," the director said.

The director of the sprawling federal prison system, which houses nearly 55,000 inmates, said he could not discuss the case further because of anticipated legal action by Mr. Chaffee's family.

Instead, Mr. Quinlan released a 14-page summary of the findings of the investigation in a written response to a federal Freedom of Information Act request filed by The News and other news organizations.

Mr. Chaffee's father, Roscoe Chaffee, of Oroville, Calif., initially labeled the findings a "cover-up." He said assigning prison employees to investigate his son's death was like "seeding the fox to the hen house."

He praised Mr. Quinlan, however, for his honesty in revealing staff insensitivity to his son's needs.

"I'm absolutely amazed that he said that," Mr. Chaffee said. "God bless him for that, but it's still no excuse."

"The inmates said Johnny was

placed in isolation because the officials were sick and tired of him complaining," said Mr. Chaffee, 70.

Mr. Chaffee said attorneys had not yet advised him on the feasibility of a lawsuit against the prison system.

Carlton Gann, a Los Angeles public defender who represented Mr. Chaffee in his bank robbery trial, said he, too, believes that his client, a first-time offender who never pulled a weapon on his robbery victims, was treated improperly.

"I can't say if his life could have been saved" by earlier diagnosis, Mr. Gann said, "but what disturbs me about it is the impression ... that when he started to exhibit symptoms, he was discredited and treated poorly because he was an inmate."

Inmates had accused prison officials of neglecting Mr. Chaffee because his death at St. Joseph's Hospital and Medical Center in Phoenix.

"John Chaffee's death was a prolonged, undignified affair that unfolded like a Stephen King horror story," fellow inmate Dannie Martin wrote in a column published July 2, 1989, in the *San Francisco Chronicle*.

Other inmates agreed that Mr. Chaffee's health had been deteriorating since February. By May, he was begging for medical help, but his complaints about headaches, dizziness and impaired walking were ignored by staff members, who thought he was faking an illness, inmates said.

St. Joseph's records obtained by The News show that Mr. Chaffee arrived with a diagnosis of brain tumor and complaints of "severe excruciating headaches" over three months, ringing of the ears and "a tendency to fall to the left" while walking.

Doctors at St. Joseph's immediately performed surgery.

"While a shunt was being placed, he underwent arrest," medical reports say. He was placed on a respirator, caught bronchopneumonia and died on June 12, medical records state.

An autopsy cited the cause of death as a brain tumor with terminal bronchopneumonia.

Prison authorities began investigating about a month later, after publication of Mr. Martin's article and a series of News articles that revealed a prison system plagued by overcrowding, critical shortages of medical staff and life-threatening delays in medical treatment.

In his summary of the investigation's findings, Mr. Quinlan said neither of the two doctors at St. Joseph's who treated Mr. Chaffee criticized the care he received in prison.

And a team of three board-certified physicians concluded that "given the fast-growing nature and critical location of the tumor, and the transient neurological symptoms Mr. Chaffee exhibited in the period immediately prior to his death, staff were not negligent in failing to diagnose the tumor earlier," Mr. Quinlan's summary said.

"The type of tumor that Mr. Chaffee had, located near the base and rear of his brain, is difficult to diagnose; it is generally found in children and not adults," the summary said. "In addition, this type of tumor is a rapidly progressive lesion with a poor patient prognosis for recovery."

"His complaints, Mr. Chaffee underwent a 'full neurological examination' by a general practice physician at the prison and then was referred to an outside specialist, Mr. Quinlan said.

After the medical team's report was presented to Mr. Quinlan, he ordered a "wider" inquiry by the agency's Internal Office of Inspections.

"It doesn't mean that the report was not well done or complete to the level it could have been, but ... I had questions that weren't answered," Mr. Quinlan said.

Among those were questions posed by inmates. About 26 prisoners were unexpectedly transferred out of the Phoenix prison on June 16 after walking out of a memorial service for Mr. Chaffee in protest of his medical treatment.

The inmates said the transfers and alleged subsequent acts of harassment are retaliation for their speaking out against their captors.

Mr. Quinlan said the transfers were due to the inmates' involvement in "a group disturbance" that involved more than the walkout.

The dead inmate's father said he hopes the attention given the case will lead to better medical treatment for inmates.

"I'm not looking for money," he said. "I'd just like to see the darn thing get corrected so that it doesn't happen to the next guy down the line."



John Chaffee ... he died of a brain tumor 10 days after prison officials, believing he was exaggerating his illness, confined him to an isolation cell.

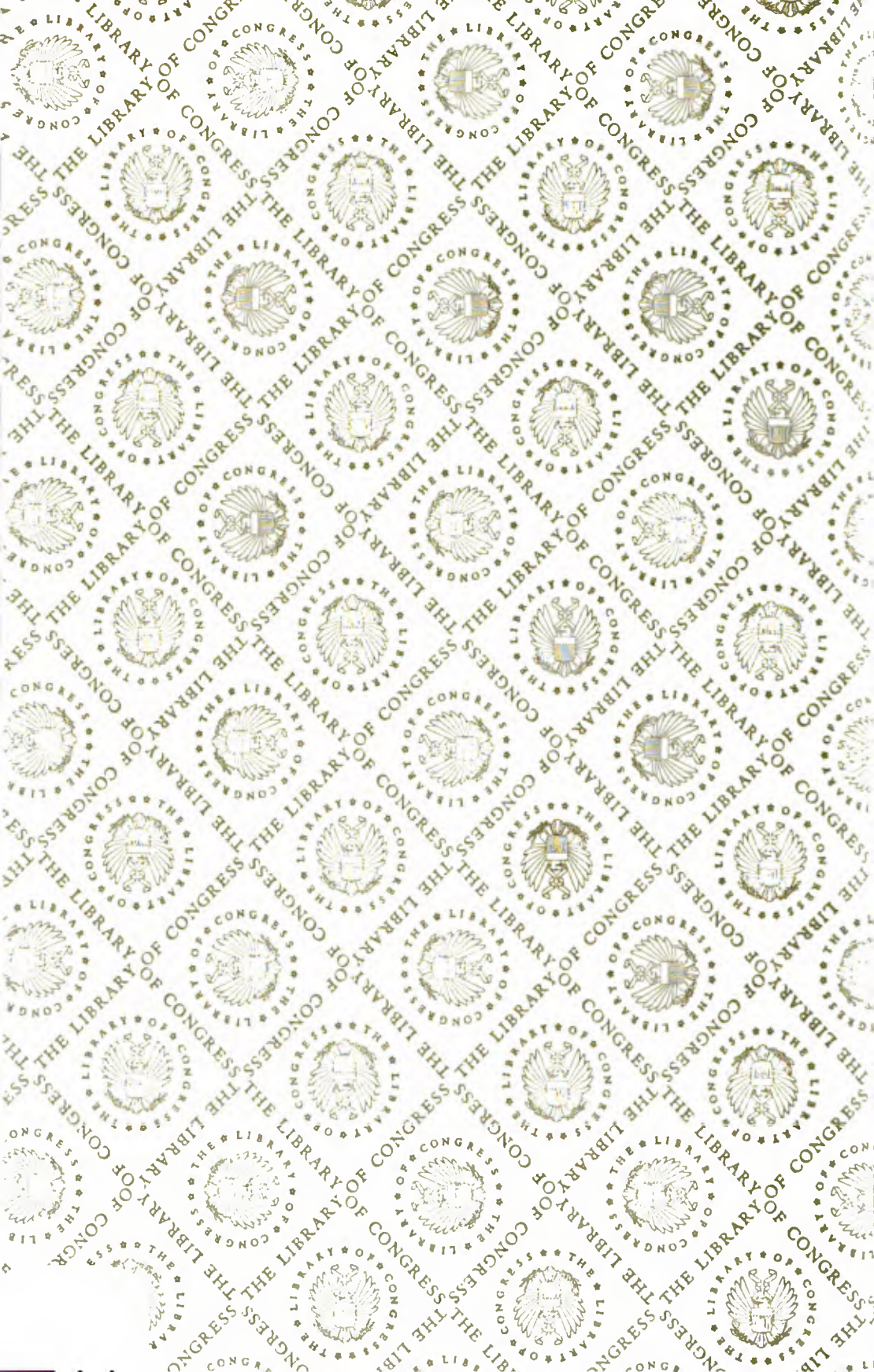
ISBN 0-16-040673-0



90000



9 780160 406737





HECKMAN
BINDERY, INC.



H185-955

Bound - To - Please
N. MANCHESTER,
INDIANA 46962

LIBRARY OF CONGRESS



0 012 356 425 A

